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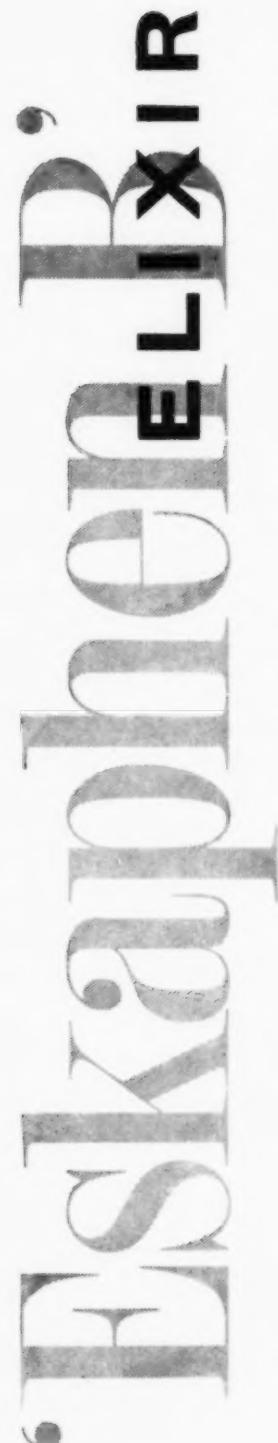
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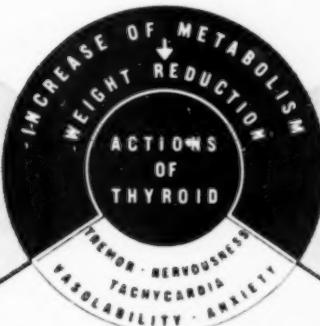
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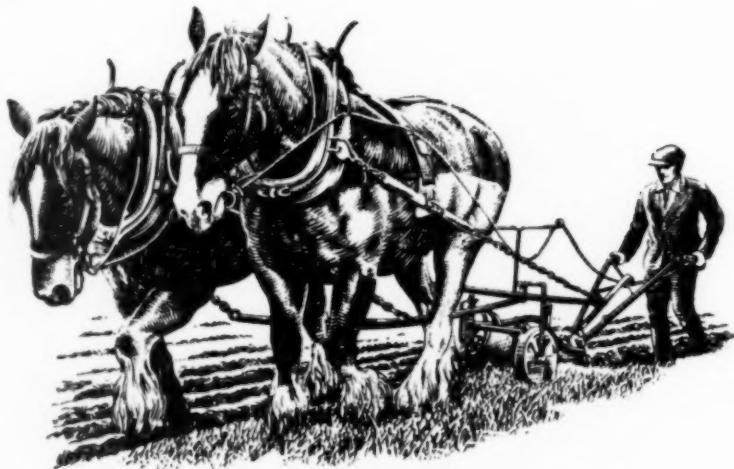
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## Suid-Afrikaanse Tydskrif vir Geneeskunde

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### BLINDNESS IN THE BANTU

#### A SURVEY OF EXTERNAL EYE DISEASE AND MALNUTRITION IN THE NORTH EASTERN TRANSVAAL

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J. GRAHAM SCOTT, B.Sc., M.D., D.O.M.S.

*Johannesburg*

The belief that the high incidence of blindness in the Bantu is largely due to malnutrition can no longer correctly be held. Trachoma has been reported by many ophthalmologists working anonymously for the South African National Council for the Blind<sup>12</sup> and by Murray<sup>13</sup>; and we have been able to confirm this by demonstrating the presence of inclusion bodies in conjunctival scrapings.<sup>1</sup> In our previous survey we also found much blindness from corneal leucomata which we assumed to be the end result of bacterial conjunctivitis. Can it be argued that a condition of general malnutrition renders the ocular tissues more susceptible to infective agents? This is a plausible suggestion, but it is not borne out by clinical experience. European prisoners of war in the Far East were grossly underfed and frequently the victims of deficiency disease, yet the incidence of trachoma and acute ophthalmia was very low.<sup>11</sup> Moreover, in the case of the virus diseases there is overwhelming evidence that a state of malnutrition considerably reduces the susceptibility of the host cells to invasion by the causal agent.<sup>14</sup>

The question is one of great practical importance because the accepted opinion must profoundly affect the choice of measures adopted to control 'preventable blindness'. Believing that more information is required before a conclusion can be reached, we have carried out a second survey of external eye disease in the Bantu and on this occasion we have paid special attention to the nutritional status of those examined.

#### THE PEOPLE AND THEIR ENVIRONMENT

The present study was carried out on 2 tribes in the North Eastern Transvaal. The first tribe was the Bavenda, who live in the foothills of the Zoutpansberg near the Donald Fraser Hospital, Sibasa. The average rainfall is 40 inches and there are many perennial springs. The people are cleanly and they grow and eat vegetables and ground nuts in addition to the staple crop of mealies. The other tribe was the Shangaan, living 30 miles further east at Thengwe in the lowveld near the Kruger National Park, where the average rainfall is 20 inches. Water is drawn from a river and used chiefly for cooking. As the Shangaan mealie crop had failed in the past 2 years, and as we went at the beginning of the rainy season in November before the new crop had grown, we expected to find more signs of malnutrition than in the Bavenda, whose crops had not failed. The reverse, in fact, was the case, though the difference was not statistically significant. We later learned that the Shangaan had been forced to eat fish from the river and stray game from the National Park to make good the lack of mealies. It was planned to mingle a small group of one tribe with the other in order to make our assessment more objective; and we did not learn until the end of the survey that this had proved impracticable. The nucleus of each group was school children. Some mothers also came with their younger infants, so we were able to compare our findings in age groups. As schooling is voluntary, we were dealing with the more enlightened section of each tribe and

one would expect to find as much, if not more, blindness in the other section.

#### RESULTS OF THE SURVEY

##### EYE DISEASES

The everted upper lids and cornea were examined in all cases. The clinical findings in the two tribes are expressed in Table I as percentages of the numbers examined.

TABLE I. INCIDENCE OF EYE DISEASES

Numbers Examined	259 Bavenda	253 Shangaan
Trachoma	6.5%	48%
Spring catarrh	19%	12%
Corneal leucoma	1%	2%
Muco-purulent conjunctivitis	1%	1.5%
Strabismus	1%	1%
Pterygium	1%	1%
Other External Diseases	Less than 1 per cent	Less than 1 per cent

The type of trachoma was milder than that encountered on our previous survey in Sekukuniland.<sup>1</sup> The usual features were redness of the lids and a few scattered follicles, while the cornea showed faint striae keratitis and fine pannus. Only a few presented the characteristics of florid trachoma—thickened red velvety lids with lacrymation, ptosis and pannus. Early changes in the palpebral conjunctiva were difficult to interpret. We saw many youngsters whose lids, when everted, had lost the normal light reflex; but we were unable to decide clinically whether this was due to early spring catarrh or to early trachoma. They were classified as spring catarrh, but microscopic examination of the conjunctival scrapings revealed the presence of Halberstaedter - Prowazek inclusion bodies (diagnostic of trachoma), in 2 out of 8 subjects so examined. This shows that our assessment of trachoma erred on the conservative side. Trachoma was also found in 22 of the adults in the complete series. In 16 of these the disease had become quiescent, leaving pannus but little superficial scarring; but in the remaining 6 and also in 2 boys of 13 years, both cornea were so severely scarred that we considered 4 nearly blind and 4 totally blind. Thus trachoma alone accounted for 4 blind people in 512, equivalent to a rate of 781 per 100,000. This makes striking comparison with the blind rate of 91 per 100,000 European in South Africa.

The seven-fold difference in the incidence of trachoma between the 2 tribes we attribute to the good hygiene and better washing facilities of the Bavenda. Flies, undoubtedly important mechanical vectors of trachoma and ophthalmia, were fairly numerous at Thengwe, but it was difficult to collect any specimens of flies at Sibasa, even in the Native huts.

We noted 7 blind eyes due to leucoma of the cornea, but fortunately in each case the other eye was unaffected. These leucomata were probably the end results of an infection which began as a simple bacterial conjunctivitis and progressed to ulceration and perforation because

the correct treatment is not available. Boase<sup>2</sup> has found the same condition in Uganda. He states that 80% of blindness is preventable, for the majority fall into the group of corneal blindness. Such white, scarred leucomata cornea are the legacy of ulceration and it is of great significance that the primary cause is usually some form of purulent or muco-purulent conjunctivitis.

Table II indicates the clinical findings in the 7 cases of leucoma found in this survey and gives unpublished figures from previous surveys.

TABLE II. INCIDENCE OF LEUCOMA

Tribe	Number Examined	Number with Leucoma	Age	Malnutrition Points	Incidence of Trachoma %
Basuto	500	0	—	n/a*	0
Bavenda	259	2	19	0	6.5
Shangaan	253	5	38	3	
			5	3	
			7	1	
			8	4	48.0
			32	0	
			48	0	
Sekukuni	503	14	2-18	n/a*	94.0

\* Not assessed.

The assessment of malnutrition by awarding 'points' is explained in the section dealing with nutrition.

In this survey only a single eye in each case was affected, so the people were not blind according to the official definition of the term; but in Sekukuniland 6 of 14 cases had both eyes affected and therefore were totally blind. Six cases in 503 is equivalent to a blind rate of 1,190 per 100,000 from leucoma alone. The ages of the cases were 2, 5, 7, 9, 9 and 14 years.

*Microscopic Examination of Stained Films.* Material for study was obtained by gently scraping the palpebral conjunctiva and superior fornix with a platinum spud. Films were prepared, immediately fixed in methyl alcohol and stained by the long Giemsa method. A period of at least 30 minutes were allowed for the microscopic examination of each film. This work was undertaken by one observer (C. R. A.) who was unaware of the clinical diagnosis at the time of observation. The main findings are summarized in Table III.

TABLE III. MICROSCOPICAL EXAMINATION OF STAINED FILMS

	Bavenda	Shangaan
Number of subjects examined	15	63
Cytology of conjunctival exudate:		
Polymorph. neutrophils	9	62
Polymorph. eosinophils	1	12
Bacteria in exudate:		
<i>H. conjunctivitis</i> (Koch-Weeks bacillus)	6	14
<i>H. influenzae</i>	0	6
Pneumococci	0	1
<i>Moraxella lacunata</i> (Morax-Axenfeld bacilli)	1	2
Trachoma inclusion bodies found	2	23

Further analysis showed that inclusions were reported in 38% of those in whom trachoma had been found by

clinical examination. This is as high as can be expected when the examination is confined to one film only. As is the case with tubercle bacilli in the sputum, repeated examinations considerably increase the chances of obtaining a positive result. The frequent association of Koch-Weeks bacilli with the trachoma agent, a fact long recognized by workers in the Middle East, is again demonstrated by the present findings. The mild form of spring catarrh which was found to be prevalent among the children did not produce any marked increase of eosinophils in the conjunctival exudate.

The examination of stained films for inclusion bodies requires considerable experience and should not be undertaken lightly. It may be useful to mention here a few of the more common errors in interpretation. The first point requiring emphasis is the fact that many of the inflammatory cells in the conjunctival exudate are actively phagocytic, ingesting fragments of disintegrating cells, bacteria, pigment granules and other foreign material. Nuclear fragments from polymorph cells are particularly liable to be mistaken for virus inclusions. There are also 2 entirely different types of granular cell, both of them frequently present in conjunctival exudates, which may be confused with the Halberstaedter-Prowazek body of trachoma. One of these is the melanin-containing cell of the conjunctiva which is mainly found in the dark-skinned races. In a Giemsa-stained film the pigment granules have a green-blue colour which renders them conspicuous objects in the field. The cells are extremely variable in shape and often have long thin processes filled with pigment which lie between the adjacent non-pigmented epithelial cells. The melanin granules are coarse and frequently so numerous that they hide the pale-staining oval nucleus. Pigment cells were present in 27 of the 63 films taken from the Shangaan, a frequency of 42%. In this series, epithelial cells containing inclusions and melanin-containing cells with their characteristic granules were found together in the same film on 15 occasions; but inclusions were never found in the pigment cells themselves. Indeed, it would be surprising if the trachoma agent, with its extreme selectivity for the conjunctival epithelial cell, could also proliferate in the melanin cell of which the origin and function are entirely different.

The second type of cell that may cause mistakes is the tissue mast cell. These cells are normally present in the sub-conjunctival connective and lymphoid tissues. They increase considerably in number during the course of any chronic inflammatory condition and are then found in the conjunctival exudate in company with lymphocytes, endothelial and plasma cells. Mast cells contain coarse basophilic granular material which is scattered throughout the cytoplasm. The granules are variable in size and show polychromatic staining with methylene blue. Poleff<sup>10</sup> has recently recommended a citric acid-methylene blue stain for the rapid demonstration of trachoma inclusion bodies. As the result of a careful trial of this new stain we have reached the conclusion that the cells which take up the methylene blue in an acid medium are tissue mast cells and not virus-infected cells. Further evidence on this point will be given in a separate publication. The photomicrographs reproduced in Figs. 1 to

4 demonstrate very clearly the differences between the true Halberstaedter-Prowazek inclusion of trachoma and these various types of granular tissue cell.

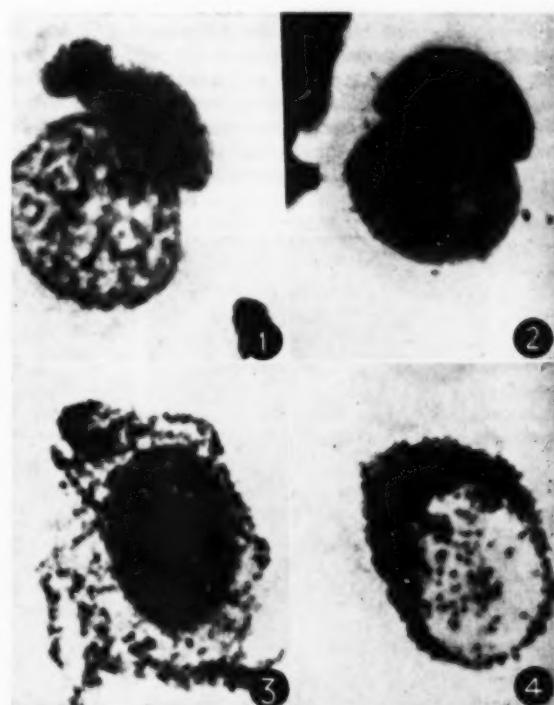


Fig. 1. A fully developed Halberstaedter-Prowazek inclusion body of trachoma in the cytoplasm of a conjunctival epithelial cell.

Fig. 2. A macrophage cell, which has ingested a large mass of nuclear material, probably derived from a polymorph leucocyte. Conjunctival exudate.

Fig. 3. A melanin-containing cell in a film prepared from a conjunctival scraping. The granular pigment is scattered throughout the cell.

Fig. 4. A mast cell in a film prepared from a conjunctival scraping. Poleff's citric acid-methylene blue stain. The basophilic granules stain metachromatically whereas its nucleus and other cells remain practically unstained.

#### NUTRITION

The state of nutrition in each individual was numerically assessed by giving a point for each abnormality

TABLE IV. ASSESSMENT OF NUTRITION

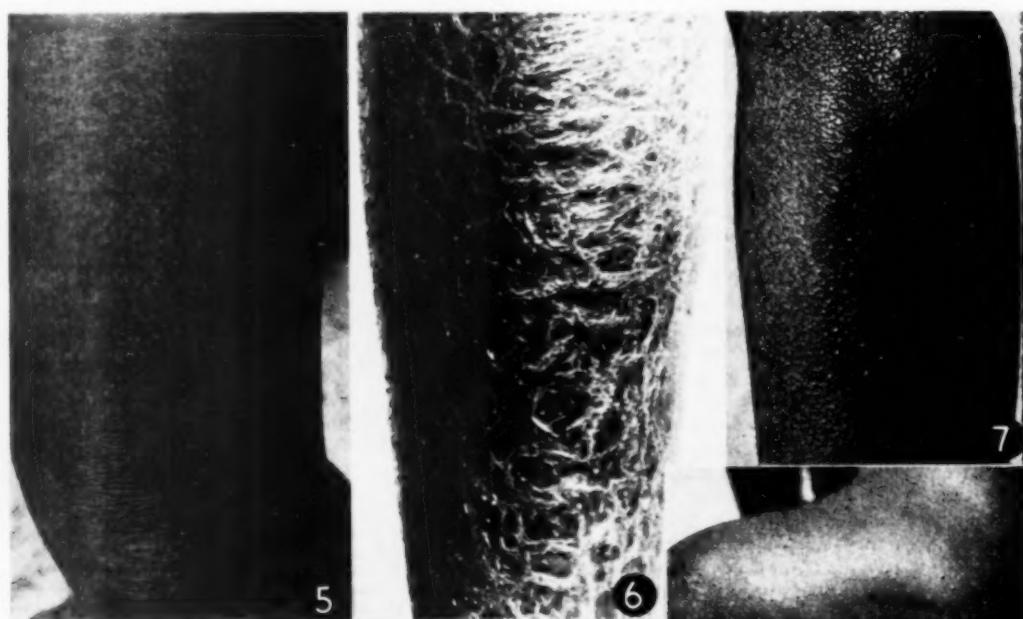
	259 Bavenda	253 Shangaan
Alteration in skin texture	104	69
Prominent follicles	33	22
Phrynodermia	9	0
Altered hair (achromotrichia at temples)	13	15
Cheilosis	10	19
Dyssebacia	3	0
Gynecomastia	1	0
Bitot's spots		
Xerophthalmia	0	0
Keratomalacia		

commonly believed to be associated with malnutrition. The frequency of such signs is given in Table IV.

The nutritional index for each group is obtained by dividing the number of points by the number of cases in the group. The index for the Bavenda is 0.67 and for the Shangaan is 0.49. However, there were many more babies in the Shangaan group and it was found that those on the breast had few, if any, signs of malnutrition. Making allowance for this, the amended index is 0.69 for the Bavenda and 0.53 for the Shangaan. Typical examples of these skin changes are illustrated in Figs. 5 to 8.

ture or other sign of kwashiorkor. Although included in the above list, we believe that the presence of golden hair about the temples is not a sign of malnutrition by itself. Prominent follicles have been regarded as a possible early manifestation of phrynoderma, but they are also known to occur in the absence of vitamin A deficiency.

This method of clinical assessment of nutrition has repeatedly and consistently shown a high degree of statistical correlation with such sociological factors as poverty and crop acreage in Uganda.<sup>3, 7, 8</sup>



*Fig. 5.* An area of follicular prominence above the knee is normal in the Bantu. This is not included among signs of malnutrition.

*Fig. 6.* Altered skin texture—advanced stage.

*Fig. 7.* Altered skin texture with follicular prominence: probably an early phrynoderma.

*Fig. 8.* Phrynoderma of mild type. No severe cases were seen.

Table V shows how the points were distributed.

TABLE V. DEGREE OF MALNUTRITION IN THE TWO TRIBES

	Bavenda	Shangaan
Number with 0 points.. . . . .	158	164
" " 1 " " " " . . . . .	57	61
" " 2 " " " " . . . . .	29	22
" " 3 " " " " . . . . .	13	4
" " 4 " " " " . . . . .	2	2
" " 5 " " " " . . . . .	1	0
" " 6 " " " " . . . . .	1	0

The alteration found in the hair was hypo-pigmentation at the temple hair margin without alteration in tex-

In recent work on nutrition at the Diepkloof Reformatory near Johannesburg a similar method of assessment has proved reliable and far more sensitive than vitamin blood estimations.<sup>6</sup> The impression gained by the member of our team (L. J. A. L.) who did all the above surveys is that the nutrition of both the Bavenda and Shangaan is far superior to that of the tribes examined in Uganda, and superior to both groups of boys at Diepkloof.

## DISCUSSION

An Editorial in this *Journal* (September, 1952), on *Blindness in the Bantu* stated that cataract and corneal lesions are the chief causes of the high rate of blindness, and that the cause of corneal lesions is not beyond dispute. We saw little cataract owing to the youth of the groups examined but there is no doubt that it is a major cause of blindness. But if the problem is considered in terms of social medicine it is the young sufferer who claims most attention. Defective vision in the young represents a loss of man-power in addition to the claims, financial and otherwise, that are made on the community. The senile blind, on the other hand, are eligible for old-age pensions, and they can not claim a blind pension as well.

This survey has shown that trachoma and leucoma are by far the most important causes of corneal lesions. Trachoma leads to corneal scarring from keratitis and is often aggravated by trichiasis and entropion. The seven-fold difference in the incidence of trachoma in the 2 tribes with similar nutrition proves conclusively that malnutrition plays no part whatsoever in rendering the ocular tissues susceptible to infection. It must be emphasized that trachoma is only slightly contagious. Repeated infection with the virus, aggravated by secondary bacterial conjunctivitis are the factors which lead to blindness; though, fortunately, this end result occurs in only a small proportion of those affected.

Leucoma is the end result of a perforated corneal ulcer. Perforation from corneal necrosis can occur without infection or inflammation in keratomalacia, a disease of malnutrition. Such cases are seen at the native outpatient departments of our hospitals and they have been described as 'clean prolapse' by Blumenthal.<sup>1a</sup> Keratomalacia, however, is associated with xerophthalmia and Bitot's spots which we did not see on either survey. We therefore conclude that malnutrition was the direct cause of few if any of the leucomata found on either survey. Usually perforation follows an infected corneal ulcer; and it is accepted that such an ulcer is more liable to perforate if the cornea is damaged by trachoma, or if the resistance of the host is undermined by malnutrition, measles, tuberculosis or other debilitating disease.<sup>4</sup>

In the cases of leucoma reported in Table II trachoma was found in neither of the Bavenda cases but in all the Shangaan and Sekukuni cases. It is also evident that the incidence of leucoma is higher in the tribe in which there is the higher incidence of trachoma. We therefore conclude that trachoma is probably a factor in the pathogenesis of those leucomata that are infective in origin. It is also shown in Table II that the malnutrition points of the leucoma cases exceed the average of the group. The data are however too small to give a definite answer to this question by statistical analysis, even assuming that the malnutrition points awarded at the survey were related to the state of nutrition at the time of perforation.

We can demonstrate no correlation between nutritional status and susceptibility to bacterial ophthalmia. Never the less, we agree that once infection of the cornea has taken place the chances of severe and permanent damage will be increased by a condition of general malnutrition.

We heartily agree with the Expert Committee on Trachoma of the World Health Organization when it

states (1952) that 'any program for trachoma control must be directed not only against the disease itself but also against related and associated conditions and against epidemic conjunctivitis'. We believe that flies are active agents in spreading ophthalmia and trachoma; and we congratulate the Health Department on a side result of its anti-malaria campaign. As a result of the widespread use of insecticides the fly population has also been considerably reduced, and we hope that this will lead in turn to a reduction of ocular infection and blindness.

Some of the modern antibiotics are effective in the treatment of trachoma as well as bacterial conjunctivitis. If facilities for the early treatment of ocular infections were made available to all, South Africa would have one of the lowest blind rates in the world instead of one of the highest.

## SUMMARY

1. Much blindness in the Bantu results from corneal lesions for which there are 2 main causes. The first of these is trachoma, an infective disease; and the second is leucoma of which the principal cause is bacterial conjunctivitis.

2. Trachoma alone was responsible for a blind rate of 781 per 100,000. On a previous survey a blind rate of 1,190 per 100,000 was found from leucoma alone. The blind rate for Europeans in South Africa is 91 per 100,000 (all causes).

3. Poleff's stain for trachoma inclusion bodies gave unsatisfactory results. In our experience the basophil mast cells are clearly defined by this method but the true Halberstaedter-Prowazek bodies remain unstained.

We wish to thank Dr. R. D. Aitken, Medical Superintendent of the Donald Fraser Hospital, Sibasa, and his staff for invaluable help in the organization of this survey.

Dr. A. M. Adelstein very kindly gave us advice on the significance of our numerical data.

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# South African Medical Journal

## Suid-Afrikaanse Tydskrif vir Geneeskunde

### EDITORIAL

#### INFLUENZA

The Expert Committee on Influenza, established by the World Health Organization in 1952, has published its *First Report*.<sup>1</sup> The report opens with these words: 'Influenza is one of the most important infectious diseases still unconquered. Even in its present relatively mild form it can cause great economic loss and dislocation of essential services, especially as its ill effects are commonly concentrated within a few weeks. It can also be responsible for many deaths; for instance, in the Netherlands in 1949, within a short period, 2,200 people died of influenza and its complications. These facts alone would make it important to learn how to control the disease; but it is even more vital to discover how to prevent or repel the attack of a lethal influenza pandemic, such as that of 1918-19, which is believed to have killed at least fifteen million people throughout the world. We do not know what led to the appearance of this outbreak in 1918, nor whether a similar one will occur again.'

This opening foreshadows what the report makes evident, that notwithstanding the knowledge that has been gained about the different strains of the causative virus, influenza still presents an unsolved problem. Medicine has put at the service of national governments knowledge concerning plague, smallpox and other pandemic diseases which has enabled them to build up defences that assure virtual security against great epidemics such as have scourged humanity in the past. But this cannot be said of influenza. The pandemic of 1918-19 caused much greater mortality than the pandemic of 30 years earlier, and there is no assurance that influenza will not again assume its pandemic form or as to what heights its virulence will reach. The sensitiveness of health departments to the increases that occur from time to time in the mortality from influenza is only too well justified.

On the epidemiological aspect the report states: '... At present it is impossible to foresee when a serious epidemic may occur. If it should occur, the condition spreads with such rapidity that there is very little time in which to initiate control measures. The committee therefore stresses the need for national administrations to obtain early information of the occurrence of an outbreak of influenza within its territory, and within neighbouring territories and other countries with which it is in frequent contact, in order to give itself, and others, time for the institution of

1. WHO Technical Report Series No. 64 (1953).

### VAN DIE REDAKSIE

#### INFLUENZA

Die Komitee van Deskundiges oor Influenza, wat in 1952 deur die Wêreldegoudheidsoorganisasie in die lewe geroep is het hul *Eerste Verslag*<sup>1</sup> uitgegee. Die verslag begin met hierdie woorde: 'Influenza is een van die mees belangrike aansteeklike siektes wat nog verower moet word. Selfs in sy huidige relatief lige vorm kan dit groot ekonomiese verlies en ontwrigting van essensiële dienste veroorsaak, vernaamlik daar die nadelige gevolge gewoonlik binne die bestek van 'n paar weke gekonsentreer word. Dit kan ook vir baie sterfgevalle verantwoordelik wees; byvoorbeeld in 1949 is daar in Nederland binne 'n kort tydperk, 2,200 mense aan influenza of die gevolge daarvan oorlede. Hierdie feite alleen toon aan hoe belangrik dit is om te leer hoe om die siekte te beheer; maar dit is nog meer lewensbelangrik om uit te vind hoe om 'n dodelike influenza-pandemie te verhoed of af te weer, soos byvoorbeeld die pandemie van 1918-19 wat volgens mening die lewens van minstens vyftien miljoen mense dwarsdeur die wêreld geëis het. Ons weet nie wat aanleiding gegee het tot die uitbreek van hierdie pandemie in 1918 nie, ook nie of 'n soortgelyke verskyning weer sal plaasvind nie'.

Hierdie inleiding voorspel wat die verslag verduidelik dat nieteenstaande die kennis wat omtrent die verskillende rasse van die kousatiewe virus ingesamel is, influenza nog 'n onopgeloste probleem is. Kennis aangaande pes, pokkies en ander pandemiese siektes is deur die geneeskunde tot die beskikking van die wêreldnasies geplaas en is hul in staat gestel om 'n bolwerk te bou wat beskerming teen groot epidemies soos dié wat in die verlede die mensdom geteister het feitlik verseker. Dit geld egter nie vir influenza nie. Die sterftesyfer van die 1918-19 pandemie was veel groter as dié van die pandemie 30 jaar vantevore, en daar is geen waarborg dat influenza nie weer as 'n pandemie sal losbars nie of watter hoogtepunt van kwaadaardigheid dit sal bereik nie. Die fyngevoeligheid van gesondheidsdepartemente oor die toename van tyd tot tyd in die influenza-sterftesyfer is maar alte terdeé geregtig.

Oor die epidemiologiese aspek meld die verslag: '... Op die oomblik is dit onmoontlik om te voorspel wanneer 'n ernstige epidemie mag uitbreek. As dit sou gebeur, brei dit so vinnig uit dat daar baie min tyd beskikbaar is om met beheermaatreels te begin. Die komitee beklemtoon derhalwe die nodigheid vir die regerings van die wêreld om vroeë inligting in te wen oor die uitbreek van influenza binne hul gebiede, en binne die gebiede van aangrensende lande en ander lande waarmee hul in noue verbanding is, om sodoende hulself, en vir andere, tyd

1. WGO Technical Report Series No. 64 (1953).

**Thank you, doctor!**



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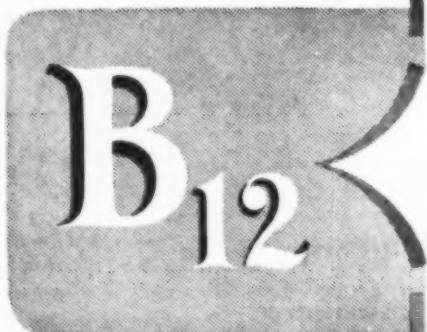
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the practical measures which can be taken to meet the emergency created by an epidemic of the disease. Early knowledge of the strain of virus involved is also necessary if specific vaccines are to be used to protect selected groups in the community.

The committee agrees that the standard practice of notifying (reporting) individual cases, which is appropriate for diseases such as typhoid fever, is inadequate in the case of influenza...

The committee is hopeful of the use of vaccines in relation to epidemics, but the limiting factor in the utilization of this measure is the speed of production. Pharmaceutical houses are reluctant to prepare for storage supplies on a mass scale which in any case might not be of the proper antigenic type. It is clear, however, that if there was a dangerous world-wide epidemic it would be impractical to manufacture enough vaccine from eggs for universal use. Key persons could, however, be immunized; and economy in the quantity of vaccine might be attained by intracutaneous inoculation or by the use of adjuvants... The committee recommends that WHO should carry out a survey of the potential production capacity of influenza vaccines at present available.

Very large quantities of antibiotics might be needed in a severe epidemic of influenza for the treatment of the inevitable bacterial complications. Present stocks of antibiotics would probably prove inadequate, and there would be a danger of the imposition of export restrictions by individual governments. The possible need for rapid expansion of commercial plants for the production of antibiotics must be visualized. On the basis of present experience, the antibiotics which would be likely to be most useful would be, first, penicillin and, secondly, those derived from species of *Streptomyces*, including aureomycin, oxytetracycline,<sup>2</sup> and chloramphenicol. The possible value of sulfonamides is more difficult to assess but should not be ignored.

It should be emphasized, finally, that the responsibility for mortality in influenza epidemics probably depends in part upon the character of the virus. The exact measure of success to be expected with antibacterial agents in a virulent pandemic is therefore to some extent unpredictable.

... It is the committee's opinion that the best approach to the prevention of influenza, at the present time, lies in prophylactic immunization, and that little hope may be expected from quarantine procedures, except perhaps in remote and isolated areas. The methods for preparing vaccine are still in the developmental stage, and further research will be needed to select the proper strains for inclusion in the vaccine, to develop appropriate production and quantitative potency assay procedures, and to determine the best method for administering the material

te wen om praktiese maatreëls te treffen om die noodtoestand wat deur 'n epidemie geskep word die hoof te bied. Vroeë kennis van die betrokke virusras is ook nodig indien gebruik gemaak moet word van spesifieke entstowwe om uitgekose groepe van die bevolking te beskerm.

. Die komitee is daarmee eens dat die standaard gebruik om individuele gevalle te rapporteer, wat doeltreffend is vir siektes soos maagkoers, ondoeltreffend is in die geval van influenza...

. Die komitee is hoopvol oor die gebruik van entstowwe tydens epidemie; maar die beperkende faktor by die gebruik van hierdie maatreël is die vervaardigingstyd. Farmaseutiese sakeondernemings is huiverig om voorrade op groot skaal vir opsameling te vervaardig, voorrade wat in enige geval nie die regte antigeniese tipe mag wees nie. Dit is duidelik egter dat as 'n gevaelike wêreldwyse epidemie uitbrek dit onprakties sou wees om genoeg entstof vir algemene gebruik van eiers te vervaardig. Persone in sleutelbetrekings kan egter ge-immuniseer word; en besparing in die hoeveelheid entstof kan moontlik geskied deur binnehuidse inenting of deur middel van hulpgeneesmiddels... Die komitee beveel aan dat WGO 'n opname moet maak van die potensiële kapasiteit om influenza-entstowwe te vervaardig wat tans beskikbaar is.

. Antibiotiese middels mag in baie groot hoeveelhede tydens 'n ernstige influenza-epidemie nodig wees vir die behandeling van die onvermydelike bakteriese komplikasies. Hierdie voorrade van antibiotika sal waarskynlik ontoereikend wees, en die gevaar bestaan dat individuele regerings uitvoerrestriksies sal toepas. Die moontlikheid moet in die oog gehou word dat dit nodig mag wees om handelinstallasies vinnig uit te brei om antibiotiese middels te vervaardig. Op grondslag van huidige ondersching, sal die nuttigste antibiotiese middels waarskynlik eerstens penicillin wees en tweedens dié wat van *Streptomyces*-soorte verkry word, insluitende aureomycin, oxytetracycline,<sup>2</sup> en chloramphenicol. Die moontlike waarde van die sulfonamides is moeilik om te skat maar behoort nie buite rekening gelaat te word nie.

. Ten slotte moet dit benadruk word dat die sterftesyfer van influenza-epidemie waarskynlik gedeeltelik deur die aard van die virus bepaal word. Die juisste mate van welslae wat verwag kan word van die gebruik van antibakteriese middels tydens 'n kwaadaardige pandemie is derhalwe onvoorspelbaar.

.... Dit is die mening van die komitee dat op die oomblik die mees doeltreffende benadering vir die voorkoming van influenza by voorbehoedende immunisasie te vinde is, en dat min verwag kan word van kwarantynmaatreëls, behalwe miskien in verafgeleë en afgesonderde gebiede. Die metodes om entstowwe te berei is nog in die ontwikkeling stadium, en verdere navorsing is nodig om die regte rasse vir die entstowwe te keur, om gesikte vervaardigingsmetodes en kwantitatiewe sterkte-toets-metodes te ontwikkel en om die gesikste metode vir die toediening van die middels aan die menslike gasheer te bepaal. Goeie verwagtings word uitgespreek oor die

2. Oxytetracycline is the international non-proprietary name for 'Terramycin' (see *Chron. World Hlth. Org.*, 1953, 7, 41).

2. Oxytetracycline is die internasionale benaming (nie die handelsnaam nie) vir 'Terramycin' (sien *Chron. World Hlth. Org.*, 1953, 7, 41).

to the human host. Considerable hope is expressed in the usefulness of adjuvants in broadening the antigenic response to the strains in the vaccine and in extending the duration of immunity. While it is realized that the available supply of vaccine will greatly limit the number of persons who can be immunized, there is hope for increase in this respect through reduction of the dose of virus by use of adjuvants.

... Significant scientific advance has been made in the past, in the study of influenza and may reasonably be expected in the future through the efforts of private or institutional initiative ...

The report ends with certain recommendations for national and international organization and co-operation in measures for the combating of the influenza menace.

gebruik van hulpgeneesmiddels om die antigeniese reaksie op die rasse in die entstowwe uit te brei en om die immunitetstyelperk te verleng. Terwyl dit besef word dat die beskikbare entstofvoorraad tot 'n baie groot mate die aantal persone sal beperk wat teen die siekte onvatbaar gemaak kan word, is daar hoop vir verbetering in hierdie opsig deur vermindering van die virusdosis as gevolg van die gebruik van hulpgeneesmiddels.

... In die verlede is betekenisvolle wetenskaplike vordering op die gebied van influenza gemaak en dit mag redelik in die toekoms van die inisiatief en kragsinspanning van individue en institute verwag word ...

Die verslag eindig met sekere aanbevelings vir nasionale en internasionale organisasie en samewerking in verband met maatreëls om die influenza-gevaar te beveg.

## DIE MIDDELOBSINDROOM

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Dit is slegs 5 jaar gelede dat 'n chroniese non-spesifieke pneumonitis van die regter middelloob as 'n aparte kliniese entiteit voorgestel is deur Graham, Burford en Mayer<sup>1</sup> gevog deur Paulson en Shaw.<sup>6</sup> Daar verskyn verskeie artikels oor die onderwerp met benaminge soos „die ingekrimpte regter middelloob“ („the shrunken right middle lobe“)<sup>2</sup> die middellobsindroom,<sup>3</sup> middellobsiekte („middle lobe disease“),<sup>4</sup> stenose van die middelloob-bronchus.<sup>5</sup> Die literatuur oor hierdie onderwerp was nog tot onlangs beperk en in die meeste handboeke is hieroor nog niks te vind nie, maar artikels oor hierdie onderwerp verskyn al hoe meer soos die meeste klinici hul reekse oor die regter middelloob aandoening enveral die röntgenbillede publiek. Dat hierdie tipe van gevalle, waar dit 5 jaar gelede vry onbekend was, al hoe meer voorkom, is nie te betwyf nie. Dit was egter wel vantevore al opgemerk en vermeld. Franklin<sup>2</sup> het in 1944 'n oorsig gegee van die prognose van brongiektaise in 'n reeks van 24 gevallen wat gereeld opgevolg is vir 4-12 jaar. Daarin meld hy van 'n pulmonale kollaps wat teenwoordig was in 10 van die gevallen, maar dui nie watter lobbe aangetas was nie. Volgens hom is dit 'n gewone bykomende beeld van unilobäre brongiektaise en blyk dit nie die prognose te invloed nie. Bes moontlik was daar tussen sy gevallen voorbeeld van die middelloob aandoening.

Reeds in 1944 het Richards<sup>1</sup> al opgemerk dat bronchiale obstruksie 'n algemene komplikasie van longtuberkulose in kinders is. In 'n verslag oor 239 kinders, ouderdom onder 6 jaar, met primäre longtuberkulose het 50 (21%) kollaps van een of ander kwab gehad as gevolg van 'n bronchiale obstruksie. In hulle serie van 66 met aangetasde lobbe (insluitende ook die bo 6 jaar ouderdom) is gevind dat die regter middelloob aangetas was in 23 (35%) gevallen; die regter onderlob was in 13 (20%), die regter en linker boonste lobbe in 9 (13.5%), die linker middelloob of lingula en linker onderlob in 6 elk, en meer as een lob was in 4 gevallen aangetas. In 32 (50%) van die gevallen het ontsporing weer spontaan plaasgevind, die kortste tydperk hiervoor was 1 maand en die langste 2 jaar. Tien uit die

64 (15.6%) het brongiektaise ontwikkel, 6 waarvan in die regter middelloob. Hieruit wil die besondere neiging tot kollaps van die middel kwab (lob) blyk. Ook by ons binne- en buitepasiënte word die diagnose van middellobsindroom al hoe meer gemaak; dit berus hoofsaaklik op die radiologie beeld van 'n skaduwee in die gebied van die middelloob, meesal kollaps, soms 'n konsolidasie of beide. Die gevalle presenteert gewoonlik by die buitepasiënte afdeling met die klages van 'n chroniese hoes, enkele weer met die beeld van 'n akute bronchopneumonie. In die afgelope jaar is 9 gevallen so meegebaar. Na aanleiding hiervan is met behulp van Dr. Straiting van die Municipale Gesondheidssiens, Pretoria, al die gegevens oor die tuberkulose gevallen, met hulle kontakte wat hulle kliniek besoek het vanaf 1948, nagegaan. Tussen sowat 4,000 röntgenfotos is nog 16 gevallen gevind wat aantasting van die regter middelloob getoon het. Hierdie bevinding toon die wenslikheid aan om na gewone opklarende pneumonie, kinkhoes of enige aanhouende hoes röntgenfotos van die longe te laat neem om sodoende die moontlikheid dat hierdie toestand aanwesig is, uit te skakel.

### ANATOMIES EN RÖNTGENOLOGIES

**Anatomie:** Dit is deur Graham, Paulson en andere aangevoerd dat die verklaring waarom die middelloob so kwesbaar vir enige inflammatoriese pulmonale aandoening is, hoofsaaklik 'n anatomiese basis het. Die regter middelloob word omgrens deur die groot en klein fissure wat dit onderskeidelik skei van die bo- en onderlob. Die mediale sy van die middelloob grens aan die regterkant van die hart, posterior is dit in verhouding tot die onderste lob en lateraal in verhouding tot die anterior borskaswand. Die ribaangrensende deel van die middelloob het 'n driehoekige vlak, die kardiale gedeelte 'n reghoekige vlak. In meer as 50% van gevallen<sup>3</sup> is die klein fissuur onvolledig of afwezig met die gevolg dat die middelloob of gedeeltelik of geheel met die boonste lob saamsmelt. Maar die grootste rede vir die kwesbaarheid van die middelloob lê

aan die rangskikking van die limfkliere rondom die middelloob-bronchus. Volgens Jenny<sup>3</sup> is die anatomie van die bronchiale boom baie verwaarloos en sommige boeke toon ook verkeerde opvattinge oor die vertakkinge van die verskillende bronchi. Die presiese anatomie hiervan word teenswoordig van al hoe meer van belang vir chirurgen, interniste, kinderartse en röntgenoloë. Die steeds uitbreidende torakale chirurgie het heelwat wysings in die opvattinge oor die anatomiese variasies van die bronchi ten gevolge gehad.

Die middelloob-bronchus het sy oorsprong uit die voorste deel van die regter stambronchus 'n paar cm. na die bolobronchus vertakking (in volwassenes). Dit is geheel omring deur 'n groep limfkliere by die geringste vergroting waarvan druk op 'n konsentriese wyse op die bronchus uitgeoefen word. By die pasgeborene is die elastiese weefsel wat onder die epiteel van die basaalmembrana van die bronchus geleë is, baie swak ontwikkel. Dit neem in dikte toe tot aan die einde van die eerste jaar; in die volgende 8-9 jaar vind daar min verandering plaas; gedurende en na puberteit verdik hierdie stutweefsel van die bronchiale wand geleidelik tot sy volwasse groeistand bereik is.<sup>9</sup> Verdere anatomiese nadelle by kinders bestaan veral uit die verhoogde gevoeligheid teen 'n te hoë of te lae intrabronchiale lugdruk, die besondere kortheid van die trachea en bronchi wat die lug nie voldoende verwarm en filtreer op pad na die alveoli toe nie. Verder is daar by kinders die gebreklike of afwesige immuniteit teenoor verskeie infeksiesiektes. Vandaar dan die groter kans tot infeksie en die maklike toedruk van die middelloobbronchus deur die daaropvolgende vergrotende limfkliere. Ook Brock<sup>7</sup> wys daarop dat tesame met die middelloob, die bronchi van die boonste en onderste lobbe van die linkerlong ook so omring is deur limfkliere en dit mag toedruk, maar veral beklemtoon hy hierdie toestand by die middelloob-bronchus. Hy verduidelik verder dat 'n verkasende klier so in 'n bronchus kan oopbreek en die inhoud die bronchus verstop dat 'n permanente striktuur obliterasie van die lumen kan veroorsaak. Verkalking vind dan nie plaas nie, daar die inhoud ontlas is; so 'n beskadigde lob mag dan vir jare sluimerend bly om op 'n latere geleenthed weer op te flikker. Jenny<sup>8</sup> is veral ook hierdie mening toegedaan.

**Röntgenologies:** Die tipiese skaduwee van die regter middelloob-kollaps was tot 1938 gewoonlik interpreteer as 'n interlobére effusie, totdat Hampton en King<sup>7</sup> aangetoon het dat 'n aandoening van die laterale deel van die middelloob 'n driehoekige skaduwee en van die mediale deel 'n reghoekige skaduwee gee. Hulle het ook beweer dat interlobére effusies baie selde voorkom, en dat 'n skaduwee in die gebied van die middelloob eerder as 'n pneumonitis interpreteer moet word.

Sy-opnames is veral belangrik omdat weens die helling van die groot fissuur die middelloob voor die onderlob met postero-anterior (P-A) opname lê, ook mag die kollapsseerde middelloob na die hilus getrek word en die ruimte so gelaat deur compensatoriese emfiseem gevul word om so die beeld te versluiwer. Dieselfde geld ook vir sy-opnames waar die hartskaduwee of digte hilusskaduwees die interpretasie mag bemoeilik. Gewoonlik egter is in die sy-opname 'n driehoekige of soms reghoekige skaduwee sigbaar (afhangende of die laterale of die mediale deel van die middelloob aangetas is), soms is die middelloob so saam-

geval dat die skaduwee niks wyer as die van 'n rib is nie (Fig. 5). Met obstruksie van die laterale takkies van die middelloob-bronchus word in die postero-anterior opnames 'n diffuse skaduwee in die onderste longveld gesien met 'n helder area tussen dié skaduwee en die hartskaduwee, maar met aantasting van die mediale gedeelte is die skaduwee langsaaie die regter hartgrens. 'n Belangrike opname, wat ook 'n duidelike en mooi röntgenologiese beeld gee, is die lordotiese (Fig. 1). Dit bestaan daaruit dat die rug agteroor gebuig word met die abdomen na vore gedruk. Met hierdie projksie word die grootste deel van die middelloob en interlobére septa parallel gebring tot die vlak van die sentrale straal en die skaduwee duideliker afgebaken soos gesien word in Fig. 1. Hierdie spesiale opname behoort aangevra te word by elke verdigte geval van middelloob-aandoening reeds met die eerste röntgenondersoek; as die gewone P-A en sy-opname verdag is van 'n middelloob-aandoening, vra die radioloog gewoonlik self vir 'n lordotiese opname wat dan weer spesial herhaal moet word, dus sal aanvra hiervoor alreeds heelwat in tyd en moete bespaar.

Tomografie kan verdere hulp verleen; plate word geneem by verskillende dieptes van die regter sy-opname. Verkalkte limfkliere en selfs tekens van vernouing van die lumina en verplasings van die lobére en lobulére bronchi en die interlobére fissure word goed aangetoon.

Bronchografie het sy welbekende waarde vir die vaststelling van die teenwoordigheid van bronchiektasie. Saamgevalle bronchi illustreer dan ook mooi die klapende middelloob (Fig. 4). Bronchografie moet altyd deur bronchoskopie vooraf gegaan word. Laasgenoemde word verderaan bespreek. Na 'n studie van 25 gevalle, word 7 nou bespreek as tipiese voorbeeld.

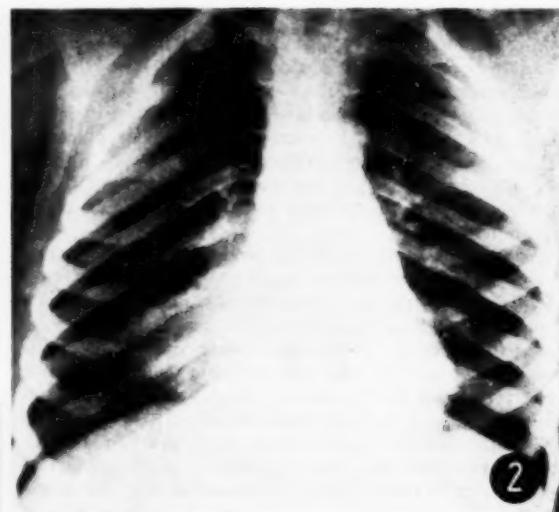
#### BESPREKING VAN GEVALLE

**Geval 1.** D. B. 'n Blanke dogertjie van 5 jaar; opgeneem met klagtes van hoes en slym op die bors vir die afgelope 5 jaar, gedurige verkoues, oorpyng en seerkeel af en toe. Die mangels is 4 jaar tevore verwyder en die sinusse ' behandel' sonder enige verbetering. Vorige siektes was Duitse masels, kinkhoes, masels, en moontlik klierkoers. 'n Oom het vermoedelike tuberkulose gehad, maar is nou gesond. Met ondersoek word 'n goedgevoede dogertjie met slegs krepitasies oor die derde ribregs gevind. Röntgenfotos toon duidelik die middelloobkollaps (Fig. 1 en 2). Mantoux negatief (PPD eerste en tweede sterktes). Sputum herhaaldelik negatief vir tuberkel basille. Bronchoskopie (Professor Bremer) toon vernouing van die regter middelloob-bronchus met 'n etterige afskeiding daaruit. Bronchogramme (Fig. 4) toon die kollaps van die middelloob met vroeë silindriese uitsetting van party van die middelloob-bronchus se takke. Sy is onder andere weer behandel met verskeie antibiotika, antihistamien stowwe en in die daaropvolgende maande onder observasie gehou. Gedurende hierdie periode het sy 2 keer otitis media gekry waarvoor miringotomie nodig was. Sy is gereeld röntgenologies kontroleer en toe daar na 5 maande nog geen verbetering in die simptome en röntgenologiese beeld opgetree het nie, is besluit op 'n middelloob-lobektomie (Professor Bremer). By operasie was vergrote limfkliere om die middelloob-bronchus gevind. Mikroskopiese ondersoek het slegs chroniese ontstekingsveranderinge getoon en geen tuberkulose nie. Sy het gou en goed herstel en kontrole fotos na 10 dae wys slegs die verwagte post-operatiewe veranderinge (Fig. 3). Haar hoes het heeltemal verdwyn en soos sy self sê: 'Die dokters het my hoes uitgesny!'

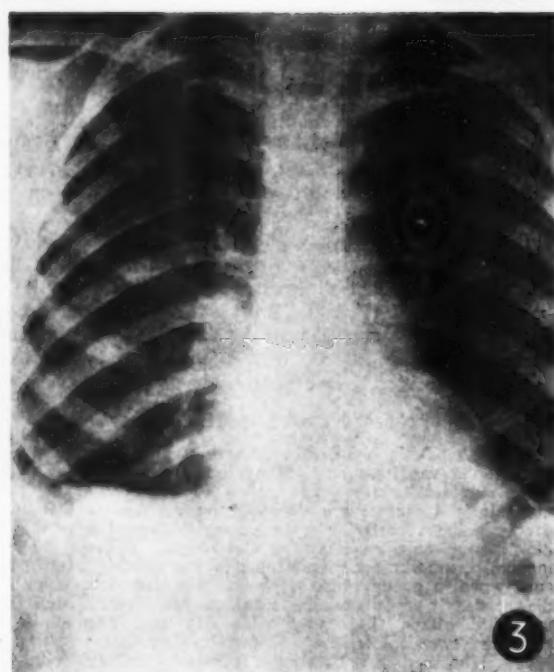
**Geval 2.** S. B. 'n Blanke dogter van 12 jaar met 'n produktiewe hoes en 'n steekpyn in haar bors vir 7 maande, afwisselende aanvalle van verkoues en seerkeel, en gewigverlies. Haar mangels is 4 jaar vantevore verwyder. Vorige siektes was bronchopneumonie, asma aanvalle tot op 4 jaar



1



2



3

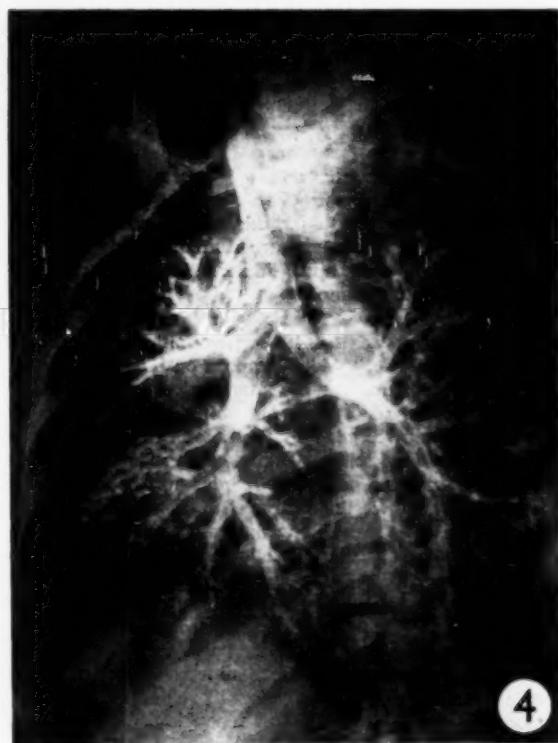
ouderdom en kinkhoes op 6 jaar. Hierna het sy eintlik die chroniese hoesie oorgehou. 'n Tante in die familie het longtuberkulose gehad. Met onderzoek kon geen kliniese awyings gevind word nie, net 'n maer langbeen dogter wat kort-kort bietjie hoes en enkele rhonchi, wat met hoes verdwyn, in albei longe het. Röntgenfotos toon 'n duidelik middellolob-kollaps (presies net soos Fig. 1). Bronchoskopie toon 'n vernoude middellolob-bronchus met 'n etterige afskeiding daaruit (Professor Bremer); bronchogramme (Fig. 4) toon 'n mate van saamklomping van die takke van die middellolob-bronchus as gevolg van kollaps met moontlik 'n vroeë verwyding van die bronchi. Mantoux swak positief. Sy is hierna met antibiotika behandel en onder observasie gehou vir 6 maande met gereeld röntgenologiese kontrole. Geen veranderinge het ingetree nie en 'n middellolob-lobektomie is gedoen. Hier ook was die middellolob-bronchus omring met vergrote limfkliere waarvan die smitte ook chroniese infeksie veranderinge toon met die afwesigheid van tuberkulose. Haar herstel was sonder moeite en die hoes en pyn het verdwyn. Sy maak goede vordering en is besig om in gewig aan te kom.

*Geval 3.* D. M., 'n Tweearige Bantoeseun wat hoes en 'n hoë koers vir twee dae gehad het, is opgeneem met die beeld van 'n akute bronchopneumonie met kreptiasies en rhonchi in beide longe. Hy is aktief met suurstof en anti-

Fig. 1. D. B.: Lordotiese opname illustreer duidelik die driehoekige skaduwee van kollaps van die regter middelloob (Geval 1).

Fig. 2. D. B.: Die P-A opname toon 'n skaduwee in die middelloob gebied, aangrensende aan die regter hartgrens (Geval 1).

Fig. 3. D. B.: 'n P-A kontrole na 10 dae na die middelloob lobektomie. Vergelyk met Fig. 2. Die voglaag is 'n post-operatiewe reaksie (Geval 1).



4

Fig. 4. S. B.: Die linker skuinsopname van die bronchogram toon 'n duidelike middelloob kollaps met aplanting van die bronchi (Geval 2).



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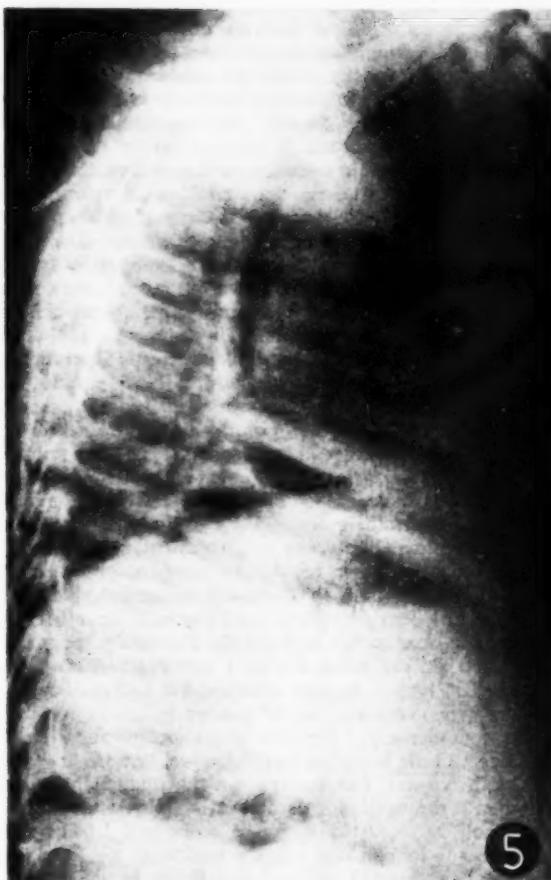
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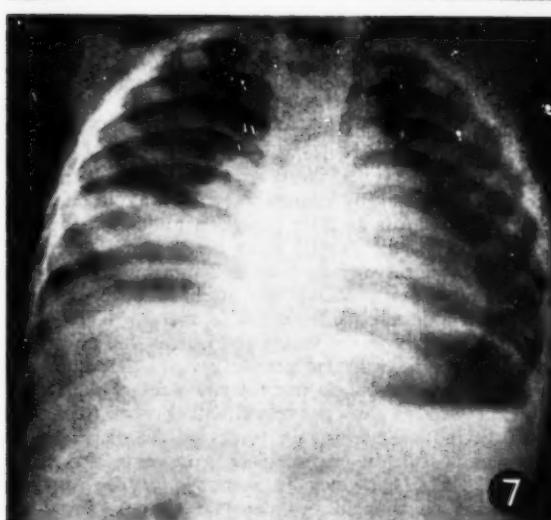


6

Fig. 5. D. M.: Regter syopname toon 'n duidelike driehoekige skaduwee wat kollaps van die middelloob aandui (Geval 3).

Fig. 6. M. L.: 'n Duidelike voorbeeld van konsolidasie van die middelloob in kontras tot kollaps. Let op die uitbulting van die wande van die driehoekige skaduwee in die syopname (Geval 7).

Fig. 7. M. L.: Die P-A opname van 'n mooi voorbeeld van konsolidasie van die middelloob (Geval 7).



7

biotika behandel. Röntgenfotos 'n dag na opname toon kollaps van die regter middelloob. 'n Kontrole na 10 dae toon dat die kollaps besig is om op te klaar en met ontslag 6 weke na opname was die middelloob so te sê reg.

Geval 4. M. L. 'n Bantoesentje van een jaar opgeneem

met 'n diaree van 14 dae en hoes vir 4 dae. Hy was gedeidreer met 'n hoë koers en krepitasies en rhonci oor beide longe. Röntgenfotos toon 'n duidelike konsolidasie van die regter middelloob (Fig. 6 en 7). Kontroles na 10 dae toon beginnende tekenes van opklaring, maar toe kry die pasiëntjie waterpokkies wat sy toestand heelwat vererger. Oopvolgende kontroles toon weer verergering van die konsolidasie met beginnende abses-vorming; kort hierna is hy ooriede. Hier was 'n lykskouing nie verkrybaar nie.

Geval 5. D. E. K. 'n Blanke man van 28 jaar, in kont geeweës met sy ouma wat bewyslike aktiewe longtuberkulose het. Hy het geen klagtes behalwe gewigswelries nie. Ondersoek toon geen afwyking nie. Röntgenfotos toon 'n duidelike area van pneumonitis van die regter middelloob. Besinking was 2 mm. die eerste uur, en 3 sputa was negatief vir tuberkel basille. Kontrole fotos na 3 weke toon volkome opklaring van die kollaps. Alleen al met rus en goeie eetgewoontes het die pasiënt 8 pond aan gewig bygekom gedurende die 8 weke.

Geval 6. M. A. V. 'n Blanke man 55 jaar, kla van pyn in die bors vir 2 jaar, geen hoes of hemoptise nie; hy het ook 2 jaar geleden 'n gastrektomie gehad vermoedelik vir 'n maagseer. Daar was geen afwykende bevindings met ondersoek te vind nie. Drie sputa was negatief vir tuberkel basille en sy besinking was 3 mm. eerste uur. Longfotos toon 'n skaduwee in die regter parakardiale streek wat moontlike konsolidasie of 'n lokaliseerde atelektase (kollaps) of bronkiktase mag aandui. Kontrole fotos toon later duidelike kollaps van die middelloob en die pasiënt word nog verder opgevolg met die oog op 'n bronchoskopie en bronchografie.

Geval 7. G. B. 'n Blanke dogter van 7 jaar wat 9 maande gelede skielikiek geword het met 'n hoë koers. Alle kliniese

ondersoek was normaal behalwe die tuberkulien jellie (Moro) toets (+ +). Daar was geen reaksie op penisillien of sulfonamide nie. Röntgenfotos toon konsolidasie van die middelloob met gedeeltelike kollaps daarby. Kontrole: na die eerste maand is daar nog gedeeltelike kollaps van die middelloob en vergrote hiluskliere; na die tweede maand 'n aansienlike mate van opklaring van die konsolidasie, maar nog groot mediastinale kliere; na die derde maand is daar nog 'n mate van kollaps van die regter middelloob; na die vyfde maand bly die beeld dieselfde; na die sewende maand is daar nog kollaps van die middelloob. Die pasiëntjie word nog kontroleer vir opvolgende bronchoskopie en bronchografie.

#### BESPREKING VAN DIE GEVALLE

Daar is nog enkele gevalle wat onder kontrole is, soos sommige van die bogenoemdes, en verdere spesiale ondersoek soos bronchoskopie en bronchografie word nog afgewag. Soos uit die geskiedenis en ondersoek van byna elkeen van die genoemde gevalle blyk, is die moontlikheid van tuberkulose steeds daar—in sommige gevalle 'n baie sterk aanduiding, in andere weer gladnie gevind na die beskikbare spesiale ondersoek gedoen is nie. So is daar ook in elke geval aanduidings van vergrote hiluskliere. Volgens die anatomiese rangskikkings van die limfekliere word dan veral die middelloob-bronchus getref en toegedruk met die gevoldlike kollaps. In enkele gevalle is daar infeksie in die middelloob teenwoording wat dan meer die beeld van konsolidasie gee. In enkele gevalle onderraan klierontsteking so gou resolusie dat klierkrimping feitlik volledig plaasgevind het met gevolg dat die middelloob-bronchus weer oopgegaan het sodat die kollaps spontaan en gou opgeklaar het. Maar waar die toestand byvoorbeeld deur herhaalde infeksie chronies geword het, is die proses onomkeerbaar en bly die beeld onveranderd. Hier is dan nou die beskryfde non-spesifieke pneumonitis van die middelloob wat ook populêr bekend staan as die „middelloobsindroom“. Die kliere kan nou nie meer inkrimp nie, of die bronchus kan nie meer oopgaan nie, of die middelloob longweefsel kan nie meer ontplooi nie, aldrie faktore wat myns insiens ook belangrike oorsake van die middelloobsindroom kan wees afgesien van die reeds genoemde non-spesifieke pneumonitis van die middelloob self. Vir sulke gevalle is chirurgie met reseksie die aangewese behandeling, anders volg broniekatasie, herhaalde infeksie met moontlike absesvorming. Dit lei tot 'n nadere besigtigting van die patologiese beeld.

*Patologie.* By elke infeksie, beginnende met 'n benigne bronchitis tot 'n spesifik tuberkuleuse infeksie, tree die limfatische sisteem tot die verdediging in werking. Die eerste skans word deur die kliere wat aan die vertakkings van die bronchi lê, gevorm, hierna die tracheobronchiale en bifurkasie kliere. Ontstekingsveranderinge lei tot vergroting van die kliere en by langdurige infeksie eventueel tot fibrose. Hier is veral die middelloob-bronchus se kliere van belang—hulle word natuurlik eerste getref deur die ontstekingsprosesse van die middelloob, maar veral ook by aandoenings van die regter onderlob en van die voorste segment van die bolob; net die kardiale segment van die onderlob dreineer direk na die bifurkasie kliere.<sup>5</sup>

Tuberkulose is hier verreweg die belangrikste oorsaak van 'n tydelike of permanente vergroting van die kliere rondom die middelloob-bronchus met die gevoldlike stenose. Reeds in 1876 beskryf Parrot die verband tussen bronchiale kliere en 'n primêre longletsel. Kuss het in 1889 die uitdrukking Primêre Kompleks hiervoor gebruik

en in 1913 het Ghon hierdie vergete uitdrukking weer in gebruik geneem.<sup>6</sup> Baie dikwels oortref die patologiese proses in die kliere die beginnende proses in die longparenchium. Zdansky noem die middelloob 'n *punctum minoris resistantiae pulmonis* omdat die kliere insluitende die hilus-kliere mees dikwels deur aandoenings van die middelloob aangetas word.

Dis nie alleen die uitwendige druk van limfekliere op die bronchus wat 'n stenose veroorsaak nie, maar 'n ontstekingsproses van die mucosa van die middelloob-bronchus self gee swelling met vernouing, dit belemmer die normale sekrete se afvloei en so 'n verergering van die ontsteking tot 'n permanente beschadiging verkry word. By kinders is die bronchiale wand so weerstand so gering dat die druk van kliere alleen genoegsaam is vir afsluiting. In Paulson en Shaw se eerste reeks<sup>7</sup> het hulle slegs in 15 gevallen vergrote peribrongeale kliere gevind en in 6 gevallen geen kliere, waar die obstruksie dan deur edeem van die bronchus self was. By so 'n aanhoudende obstruksie volg uiteindelik die chroniese peribrongeale pneumonitis en fibrose, broniekatasie ontwikkel uiteindelik in die distale bronchus, maar laasgenoemde is nie juis 'n prominent beeld in die patologie nie.

Die onvermydelike vraag by 'n pasiënt met 'n middelloobsindroom ontstaan van die toestand nog omkeerbaar is of nie en hoe lank so 'n pasiënt onder kontrole gehou moet word. Jenny<sup>8</sup> verwys na 32 gevallen deur McPherson gevolg waaruit net in 4 gevallen die kollaps permanent gebly het. In die helfte was na 1 jaar die middelloob weer normaal en lughouend en sommige het selfs na langer as 'n jaar weer volkome herstel sonder enige parenchiateuse veranderinge. Behalwe die kliervergroting en die swelling van die bronchusslymlvies speel tumore 'n geringe rol as 'n oorsaak van kollaps van die middelloob. Karsinoom van die middelloob is baie meer seldsaam as wat 'n mens sou verwag. In Jenny se reeks van 1.040 gevallen van maligne longtumore was die middelloob net by 14 die setel van die primêre tumor. Uit Brock se 1.200 gevallen van bronchuskarsinoom was net 8 in die middelloob gekry—dit was ook van die parenchiateuse tipe en nie een van die middelloobbronchus self nie. Tog bly 'n mens altyd verdag hiervan in pasiënte in die karsinoom ouerdom.

*Symptomekompleks en Diagnose.* Die belangrikste symptome volgens Paulson en Shaw bestaan uit 'n chroniese hoes, pyn, hemoptise, gewigsverlies, dispnee en hygge ('wheeze'). Laasgenoemde twee waarneminge is in hierdie reeks slegs gemaak by kinders wat met 'n akute pneumonie beeld opgeneem is en later geblyk 'n middelloob aantasting te wees, of by die gevallen waar die toestand vererger en oorgaan tot absesvorming, soos in 2 van ons gevallen gevind is. Symptome in hoofsaak van 'n chroniese hoes gepaard met herhaalde bronchitis aanvalle met 'n bietjie koers, verkoues, gewigsverlies, vorige geskiedenis van pneumonie was veral in die volwasse gevallen gevind. Die duurte van die hoes kan van enkele dae tot jare wees of die toestand kan 'stil' wees en slegs per toeval ontdek word (in 5 uit die 2.480 gevind). Daar is min tekens en die diagnose berus hoofsaaklik op die radiologiese voorkoms wat alreeds bespreek is. Daar mag in sommige gevallen verspreide krepitasies en rhonchi oor die middelloob te hore wees; doofheid met perkussie kon in die bestaande gevallen nie gevind word nie. By byna die meeste gevallen was daar klinies in die longe niks te vind nie.

## BEHANDELING

1. Die meeste skrywers beveel konserwatiewe behandeling aan vir 'n wisselende tydperk van maande tot jare met gereelde kontrole. Daar is baie gevalle alreeds beskryf wat spontaan opklaar. Gewoonlik het die pasiënte teen hierdie tyd al verskeie kursusse van antibiotika gehad en die mangels lê al lankal in die bakkie; indien nie, kan enige van die nuwere middels soos Terramycin en die ander probeer word. Die reaksie op die antibiotika hang natuurlik af van die gevoeligheid van die veroorsakende organisme daarvoor. As die infeksie eers opgeklaar het, hang dit af van wanneer die limfkliese weer gaan krimp tot hul normale grootte en wanneer die middelloob-bronchus weer oopgaan en die middelloob weer self ontplooи.

2. *Bronchoskopie*. Hierdie is 'n waardevolle manier van behandeling afgesien van die diagnostiese toepassing. Indikasies is veral pasiënte in die karsinoom ouderdom met 'n chroniese hoes, hemoptise en hyging; in jonger persone vir die moontlikheid van bronchiale adenome; en in andere gevallen met herhaalde pneumonie en pleuritis aanvalle, wat natuurlik ook 'n middelkwab aandoening het. In enkele gevallen geluk dit om die uitbulting van so 'n klier in die bronchuslumen te sien, dit word dan dopgehou en as die klier versag of verkaas en in die bronchus uitsweer, word die materiaal afgesuig net voor dit ontlas in die lumen. Pogings kan ook aangewend word om die gewone infeksiesekresie af te suig, hoewel dit nie suksesvol was in gevallen 1 en 2 nie.

3. Voorbehoeding tot die ontwikkeling van bronchiektase terwyl die pasiënt nog kontroleer word. Postuur-dreinering as dit reg gedoen word, is van groot waarde. Jones en ander<sup>11</sup> beveel ook stoominhalsies en die gebruik van aminofilien aan.

4. Algemene maatreëls, veral waar die diagnose van tuberkulose sterk op die voorgrond tree, maar nie bewys is nie. Hier word bedoel goeie versorging, voeding, rus, sonlig, ens. Heel party van hierdie reeks gevallen is slegs op hierdie manier deur die Tuberkulose Kliniek behandel.

5. Chirurgiese ingreep met reseksie. Die verwydering van die aangetaste middelloob is al wat oorbly as die toestand onomkeerbaar is. Dit is moeilik om te besluit hoe lank die pasiënt onder kontrole moet bly om te sien of spontane opklaring nie gaan plaasvind nie. Maar as die kliniese simptome dieselfde bly of vererger, moet reseksie sterk aanbeveel word. Die ontwikkeling is tog in die rigting van bronchiektase. Met die verdenking van tuberkulose as 'n etiologiese faktor, kan die reseksie onder 'n skerm van Streptomisien gedoen word.

6. Die komplikasies soos absesvorming en empieem word op hul eie meriete aktief en met sorg behandel. In 2 van die reeks gevallen het Penicillien, Streptomisien en Aureomycin niks gehelp nie, en is hulle uiteindelik oorlede.

## OPSUMMING

Die middelloobsindroom, eerste beskryf deur Graham en andere as 'n non-spesifieke pneumonitis in 1948, word teenswoordig al hoe meer raakgesien. Die anatomie van die regter middelloob met die limfkliese rondom die middelloob-bronchus maak kollaps met infeksie maklik. In kinders veral kan die bronchiale wande maklik toeswel-

met infeksie en kan vergroting van die limfkliese dit maklik toedruk.

Die diagnose berus hoofsaaklik op die röntgenbeeld, veral die lordotiese opname waar die tipiese driehoekige skaduwee mooi te sien is. Tomografie is ook van waarde, terwyl bronchoskopie as 'n behandelings- en verdere diagnostiese-metode ook baie gebruik word. Bronchografie toon of daar bronchiektasie is al dan nie.

Na 'n oorsig van 25 gevallen met middelloob aandoening word 7 as tipiese voorbeeld beskryf. Klage van langdurige hoes, hemoptise, koorsaanvalle en gewigsverlies behoort tot verdere röntgen en andere spesiale ondersoeke te dwing. By byna al die gevallen is daar 'n geskiedenis van kontak met longtering, maar tuberkulose kon in die meerderheid van hierdie gevallen nie vasgestel word nie. Sommige presenteert akut soos 'n pneumonie, andere weer met bogenoemde klages en party is sonder enige simptome en tekens en word bloot deur roetine ondersoek ontdek. Enkele van die gevallen klaar spontaan op, ander bly onveranderd of vererger ten spyte van aktiewe moderne antibiotiese behandeling. Reseksie van die aangetaste kwab word aanbeveel by gevallen wat staties bly of vererger. Redes hiervoor word gestel as 'n onvermoë van die infeksie om op te klaar, die ontwikkeling van bronchiektasie, limfkliese wat nie herstel nie, 'n bronchus wat stenoties bly en derhalwe 'n middelloob wat nie weer ontplooи nie.

Dit is nog onseker hoe lank die gevallen konserwatief behandel moet word voordat tot chirurgie oorgegaan word.

## SUMMARY

The middle lobe syndrome is being studied extensively nowadays. The anatomy of the middle lobe and its bronchus with lymph gland arrangement, soft bronchial walls and the presence of infection, predispose to this syndrome. Diagnosis is confirmed by X-ray studies, especially the lordotic projection, where the typical triangular shadow is seen more easily. Tomography and bronchography are of value, the latter especially for the demonstration of bronchiectasis. Bronchoscopy is valuable not only as a diagnostic procedure, but also for therapeutic purposes.

This paper reports a study of 25 cases of middle lobe syndrome. Symptoms of chronic cough, haemoptysis, pyrexial attacks and loss of weight are indications for the above-mentioned special investigations. Proved pulmonary tuberculosis was found in near contacts of most cases although Koch's infection was not proved in the majority of the cases studied. Sometimes the middle lobe syndrome was discovered accidentally in the absence of symptoms. A few cases cleared up spontaneously. Others remained unchanged, or became worse in spite of antibiotic treatment. In the latter group of cases, because of continuous bronchial obstruction, resection is indicated. It is as yet uncertain for how long conservative treatment should be continued before deciding on surgery.

My dank is verskuldig aan die volgende: Professor J. G. A. Davel onder wie se leiding hierdie ondersoek gedoen is; Dr. H. Nelson, Hoof-Gesondheidsbeampte van Pretoria vir sy toestemming tot die gebruik van die Tuberkulose Kliniek gevallen; Dr. Strating, vir sy hulp met die uitsoek van die gevallen en die röntgenfotos en die Superintendent van die

Pretoriase Algemene Hospitaal vir sy toestemming tot publikasie van sommige van die gevalle.

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## SKIN GRAFTING OF THE EYE SOCKET FOLLOWING EXENTERATION OF ORBIT

R. L. H. TOWNSEND, M.R.C.S., L.R.C.P., M.B., B.Ch., D.O.M.S., R.C.P. & S. (ENG.)

Cape Town

The object of this communication is to draw attention to a procedure which is not new, but may not be as fully appreciated as it should be.

When a skin graft is applied to the bare bone of the orbital cavity, after exenteration of the orbit, it does in fact 'take', and in so doing greatly hastens recovery and eliminates the painful dressings which are a feature of the post-operative period, when the socket is left to granulate and epithelialize over a period of many weeks.

Fortunately, exenteration of the orbit is one of those unpleasant and mutilating operations which any individual ophthalmologist is not often called upon to do. One is usually driven to it in an attempt to preserve the life of the patient, from the dire effects of some malignant growth of the eye or its adnexa.

This patient was a European male aged 58 who, in the last 4 years, had had benign melanomata of the conjunctiva removed by diathermy excision on 3 occasions. The benign nature of these was reported on by Drs. Finlayson and Clegg. In October 1952 he returned 18 months after his third excision of conjunctival melanoma with an unpleasant-looking, lightly pigmented growth in an entirely new site, i.e. at the corneo-scleral margin. There was also a rather fleshy looking, slightly pigmented growth over the site of a previous removal. The appearance of these new growths was different from the earlier ones, being more vascular and more fleshy, and less pigmented.

A diagnosis of melanotic sarcoma was suspected, but as such a diagnosis would necessitate exenteration owing to its diffuse involvement of the conjunctiva, it was decided to excise the limbal growth by diathermy needle to establish the diagnosis before resorting to this mutilating procedure. The pathologist reported that this specimen was without doubt a malignant melanoma.

The exenteration operation was carried out with the assistance of a plastic surgeon. This involved an incision right down to bone, around the orbital margin, and removal of the entire orbital contents, including periosteum.

Dr. Davies (who assisted me) had previously cut a Thiersch graft from the inner side of the thigh; this he laid upon *tulle gras*. After complete haemostasis had been achieved, he manoeuvred the skin graft, still adhering to the *tulle gras*, with its raw surface in contact with the bony walls of the orbit. He then packed the



Fig. 1. Exenterated socket: front view.  
Fig. 2. Exenterated socket: side view.  
Fig. 3. Prosthesis *in situ*.  
Fig. 4. Prosthesis *in situ*, with glasses.  
Fig. 5. Actual prosthesis: front view.  
Fig. 6. Actual prosthesis: side view.

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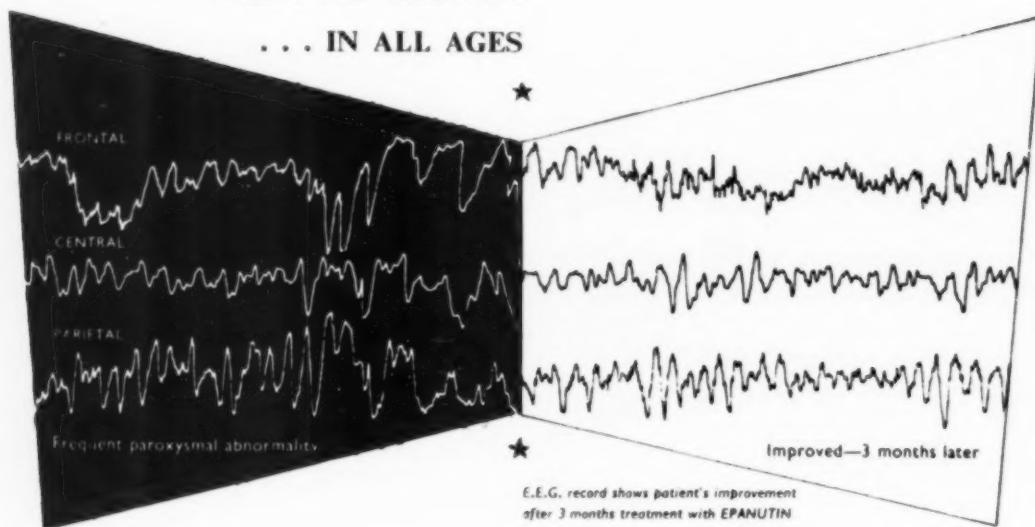
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socket, first with ribbon gauze soaked in aqueous Acriflavine 1:1000 and wrung out, then with cotton wool pledgets similarly treated. Finally a dry cotton wool pad was strapped firmly over, by means of Elastoplast, and then a bandage was applied.

The patient suffered very little pain or shock. The first dressing was done quite painlessly on the seventh day, and the socket repacked. A second dressing was done on the twelfth day, and the patient returned home. This dressing was finally removed on the eighteenth day, the graft having taken completely.

The patient was subsequently fitted with a prosthesis, very skilfully and artistically constructed from plastic materials by a plastic technician, and the final result is shewn in Figs. 1—6. The patient, a lecturer, is able to face his class again without embarrassment.

#### SUMMARY

A case of exenteration of the orbit is described, in which convalescence was considerably shortened by the application of a skin graft, and an excellent cosmetic result obtained by a satisfactory prosthesis.

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### FURTHER REPORT ON POST-GRADUATE TRAINING IN GREAT BRITAIN\*

By DR. JAMES BLACK

Following on my report of 11 July 1951, I now herewith forward you some further observations and comments.

There is now no need for me to enter into details regarding the hospital and specialist services in connexion with the National Health Service of Britain. These have already been dealt with by Prof. Dart in his report of 30 May 1950 and by our President in his report of 19 August 1951. I think, therefore, that it would be more profitable to you if I endeavour (1) to convey to you some of the impressions I have gained regarding the present trends in post-graduate education in Britain, and (2) to comment on what bearing I think these trends may have on our attempt to improve the standard of specialism in the Union. My previous report has already dealt with some points.

I should like to state in the first place that the health authorities in Britain are dealing with a huge new experiment, one which was brought into being probably in too great a hurry with the result that changes are very frequently being made with the intention of improving the service. The result is, an outline given of the scheme as it is to-day may require to be definitely altered in 6 months' time; this refers particularly to the length of time of post-graduate training for specialization and the names given to the various trainee posts.

Let me say that it seemed to be a very general opinion that under the new scheme the post-graduate training would be on a much more satisfactory basis, would be more thorough and likely to lead to a higher standard of specialism. Perhaps I should say however that this opinion was held more strongly by the more senior men, the men who are responsible for the organization of the scheme. Among the more junior consultants and the trainees such unanimity of opinion was not found. Many of them felt that now more than ever advancement would depend on the favours of a few.

At any rate I think it can be said that anyone who has reached 'consultant' status on the Hospital Service is really well trained, for he has spent at least 2 years training in full-time hospital posts preparatory to his 5 years' training for his speciality; the latter entails 2 years as registrar and 3 years as senior registrar, both of them being full-time posts

and there is talk of the 3 years' senior registrarship being increased to 4 years.

It should be noted also that a trainee does not automatically progress from senior house officer to registrar, senior registrar and consultant. In Scotland for instance a Board of Studies is set up to deal with each speciality, and this Board decides which trainees will be advanced. All factors are considered, such as records as a student, records re post-graduate degrees, records submitted from chiefs re clinical ability, character, personality, etc., etc. Sir Francis Fraser informed me that during the 6 years of training, he and his assistants (one for each of 4 metropolitan regions) who supervise this post-graduate education in London, know each individual trainee very well and know his full record and are, along with the other members of an election committee, in an excellent position to judge who is the most suitable and best qualified individual to be raised to the rank of consultant. Scores may apply for such a vacant post. What I wish to stress is that all these posts are now really competitive and according to the authorities only the best men win, and therefore it is thought that the hospital specialist service is likely to have its standard raised considerably.

But it has its defects. (1) Unless a student has a good academic record he is unlikely to be considered as a suitable trainee and therefore unlikely to obtain a registrarship. (2) A medical practitioner who has been in general practice for 2 or 3 years seems to me to have very little hope of ever changing from general practice to specialization and hence a newly qualified graduate is almost forced to decide during his intern year whether he will become a general practitioner or endeavour to specialize. (3) Having obtained a registrarship (during which time he is expected to obtain a higher degree or diploma) he may be advised at the end of these 2 years, or before, that the Board of Studies cannot recommend his candidature for a senior registrarship. If this be so, then his alternatives are to enter general practice or try and see what prospects there may be in another speciality. (4) Even if he obtains a senior registrarship there is no guarantee that he will ever reach the rank of consultant, in which case his plight is rather an unfortunate one for he cannot remain on the hospital service indefinitely. He can then enter general practice, and some authorities state that as the result of his

\* A report presented to the South African Medical and Dental Council in March 1952.

specialist training he will make a better general practitioner. But under the general practitioner service he cannot set up practice in any particular town where he would like to settle, but must wait till he can obtain a general practice which has been advertised by the authorities and he must take his chance among very many other applicants. He may apply for an assistantship to another general practitioner, but I have been told that most general practitioners who require, or wish to have, an assistant, would prefer someone who has had some general training rather than one who has devoted years to some special subject. For anyone who has devoted 5 or 6 years to specialist practice in hospital to be forced to enter general practice, as it is practised in many places in Britain to-day, must be a depressing prospect.

In fairness however, it should be stated that up till now there have been too many registrars and senior registrars in the Service. The reason for this is that far too many doctors were encouraged, assisted by financial grants, to specialize when they were demobilized at the end of the last war. This is being remedied to some extent now by a reduction in the number of trainees, but there has been much disappointment and heart-burning among the demobilized doctors.

It should be noted also that for those who have qualified since the war 2 years' military service is compulsory. There are differences of opinion expressed as to the value of this training from the purely medical point of view. Probably its value differs according to the type of post. I wish to point out however that this 2 years' military service adds another 2 years to the age when a man can become a consultant. It will be seen therefore that with a 6 years' undergraduate training, a year's internship, a 6 years' specialist course and 2 years' military service it is impossible for any one to reach the rank of consultant till he is 32 years of age, and to accomplish this he must have commenced his first undergraduate year at the age of 16 and have had no setbacks. For those who wish to take an arts and/or science degree before entering on a medical course or who for any reason are older than 16 years of age before starting a medical course the desired goal of 'consultant' is reached at a correspondingly later age.

I have endeavoured to formulate these points in order to try and contrast our own system in the Union with the system prevailing in Great Britain, in the hope that something can be done to improve our standards here.

May I say that I am well aware that our present method of placing the name of a speciality after a registered person's name in the register is by no means ideal, for such an act undoubtedly tends to give the public the impression that these men have been passed by our Council as specialists in their own particular line, whereas all such an act implies is that the Council is satisfied that the individuals have undergone a certain minimum training in that speciality and that they are limiting their work to such a speciality? (Incidentally something might be done to enlighten the public regarding this position and also to endeavour to educate them to the fact that the general practitioner is still the best judge as to the merits of various specialists in each individual case of illness.)

How does the standard in Great Britain compare with our own? I am forced to the conclusion that there is no doubt that by the time a man becomes a 'consultant' on the hospital service in Britain he is a well-qualified specialist. He must be well qualified or he would never have reached that position. We cannot say that of those who are on our so-called specialist register, as their minimum training has been definitely less in most cases, their ability as specialists has not been judged by their specialist colleagues, nor have they had to compete in any way for their positions.

That does not mean we must adopt the British system, to which there may also be drawbacks. For one thing it could only be adopted where a country has a National Health Service and all the hospitals come under the control of such a Service. Here in the Union sufficient posts are not available. This is unfortunate, for I consider it would raise the standard of specialism here very considerably if every specialist was compelled to have a senior hospital appointment. At present however such a proposition seems to me impracticable. Incidentally, authorities in Britain say that the insistence on holding a hospital appointment prevents the

emergence of the quack specialist who is apt to develop an undesirable type of practice in the West End of London. A hospital appointment means contact with, and criticism from, one's colleagues and therefore is a stimulant to better work; the hospital is a clinical specialist's laboratory.

But if we cannot adopt the British system, is there anything else we can do to improve our own specialist standard? I would appreciate very much the views of all members of the Council on this important subject and would value a debate by the full Council in the hope that some more satisfactory scheme might be evolved. Personally I cannot proound any other more suitable plan for this country than we have at present, conscious though I am of its many deficiencies. It seems to me impossible to return to the so-called 'good old days', when anyone could call himself a specialist. I think the members of the profession and the public would insist that some minimum standard of training be laid down. Neither does it seem to me possible to put the clock back 40 to 50 years (when there were hardly any specialists in this country) and depend on the reputation a general practitioner may have gained among his fellow practitioners. To my mind that era has passed. Furthermore much legislation, as well as medical-aid-society practice now depends on the so-called specialist register.

If various Medical Colleges existed in South Africa as they do in Britain some arrangement might be evolved whereby the Council regulations re training would be carried out and the Colleges would be asked to decide who are fit to become specialists. Some arrangement of this nature exists, I think, in Canada. As, at present however, no such College exists here such an arrangement cannot be considered though it might be considered in the future.

As I can find no other suitable system that we can adopt at this stage I can only suggest that our present standard should be raised by increasing the length of time which a trainee must spend over his training for his speciality to bring it more into line with the training elsewhere. Roughly our regulations for most specialities require a minimum of 1 year's internship, 2 years' general practice and 3 years' training in the speciality or subjects relating to it. I submit that the last requirement provides too short a time for the trainee to obtain sufficient experience in his speciality; it is a much shorter period than that required for consultant status in Britain and I think it is a shorter time than is required in most countries. I am of opinion that the length of time should be increased from 3 to 5 years on an average and that this should be made possible by the elimination of the regulations making 2 years' general practice compulsory.

Having had many years of general practice before becoming a specialist, I am well aware (as I have often stated before) of the great advantages of such a course. I am also well aware of the opinions expressed by the large bulk of general practitioners in our recent referendum. In spite of these 2 factors (and I do not lightly go against the opinion expressed by my general practitioner colleagues) I have changed my mind regarding the necessity of this 2 years' general practice. As the result of experience as Chairman of the Specialist Committee, as the result of studying specialism in this and other countries, and as the result of noting and appreciating the difficulty from the financial point of view of giving a long enough term of years of training in the speciality and at the same time a long enough time in *satisfactory* general practice, I have become convinced that 2 years spent in the study of the speciality will be much more valuable for any trainee than an enforced 2 years of general practice. Note that we cannot have any sort of control over the type of general practice; the candidates' word must be accepted. I think we must realize that being a general practitioner for 2 years does not necessarily connote a good specialist, nor does the lack of 2 years' general practice connote a bad specialist. Much more depends upon the ability, judgment and personality of the individual. I become more and more convinced that we can become too hidebound with regulations and that it would be wiser to allow some play to individuality. (Since this was written, new rules have been promulgated permitting alternatives to general practice.)

I took the opportunity while I was in Britain of discussing this regulation re 2 years' general practice with several colleagues interested in post-graduate education in fact as I

mentioned in my previous report I was questioned about it) and it was an almost universal opinion that the regulation is too idealistic and not practical nowadays. Very few specialists in Britain have been in general practice and yet the standard of specialism in Britain is very high. The average standard of general practice under the new Health Scheme is however very definitely low and I cannot see that 2 years in general practice in Britain would produce a better specialist.

To encourage the right type of general practitioner to become a specialist, however, I think that credit should still be given for so many years in general practice, the amount of credit varying with the length of time spent in general practice and with the type of speciality; e.g. I think much more credit could be given for the speciality of Medicine than for the speciality of Surgery. (Under the new rules such credit is now given.)

Regarding the question of the opportunities available in Great Britain for the training of our South African post-graduates varying opinions were expressed. Some thought that the National Health Service would undoubtedly curtail the opportunities for overseas graduates to obtain full-time posts of responsibility, the type of post on which we as a Council insist.

It was pointed out to me that in the teaching hospitals there is great competition now for the posts of registrars and senior registrars, and the competition is from British graduates. These posts are likely to be given to those who intend to complete the 5 years' course and remain in Britain. As far as I can see it will be difficult for a South African to get one of these posts and I think this was well brought out in the scheme which Sir James Learmonth at first envisaged. You will remember how it was suggested by him that South Africans might be included in this training scheme, but I fancy that it has been found that sufficient posts are not available to allow of this. At any rate I was interested to note Sir James' reply as to whether an 'observer' South African trainee would have any responsibility. He was quite definite that he could not guarantee this and expressed the opinion that an overseas graduate should learn his operative technique and have his responsible posts before coming to Britain and that he should then travel about to 'observe' the different techniques and methods in use in other countries.

This increasing difficulty in obtaining suitable posts for overseas graduates was stressed by Dr. H. R. Sandiford of the Empire Medical Advisory Bureau of the British Medical Association, by Mr. Davies, Secretary of the Post-Graduate Education Committee of the Royal College of Surgeons, England, and by Dr. Walker, Secretary of the British Medical Association in Scotland.

One must remember that financial implications may also have a bearing on the subject for the service is now really a Civil Service one and the salaries paid to the registrars and senior registrars are from £775 rising to £1,300 per annum. I was fortunate to be introduced to the Chief Accountant of the Service in Scotland, Mr. Stirling, and besides giving me much valuable information regarding the service, salaries, etc., he mentioned that the question of remuneration or lack of remuneration for overseas graduates obtaining such posts had never been discussed and might have a bearing on a decision. I think it might be wise for discussions on this question to be conducted on a high level.

While I think the consensus of opinion is that there will now be greater difficulty for our graduates to obtain posts such as registrarships in the teaching hospitals, Sir Alexander Biggam, who is a specially appointed Dean for Post-Graduate Education in Edinburgh, was not so pessimistic. He saw no reason why it should not be agreed that a certain percentage, say 2%, of registrarships should be reserved for overseas graduates, and he instanced the fact that 2 South African graduates now held these posts in thoracic surgery in Edinburgh.

On the other hand there is no doubt that various organizations throughout Britain are very interested in doing everything they can to assist overseas graduates to obtain suitable posts; indeed I think our post-graduates owe a debt of gratitude to them for the unselfish work which is being done on their behalf.

Chief among these organizations is the British Post-Graduate Medical Federation in London with Sir Francis Fraser at its head. A similar body exists as I have stated in Edinburgh. The various Royal Colleges also help. The British Medical Association through its Empire Medical Advisory Bureau assists in the same way. I visited London House also and was much impressed by the amount of excellent work which is being done there on behalf of overseas graduates. Not only is it an excellent place of residence with all kinds of advantages, not easily obtained anywhere else in London, but the administrative staff, from Brigadier Pepper downwards, are unsparing in their efforts to assist our men in obtaining the required posts, in giving introductions and in assisting them in every way they can. In Oxford also I found 2 post-graduates who were holding excellent training posts through Nuffield Scholarships. It will be noticed therefore that posts can still be obtained for post-graduate training purposes in Britain.

I wish to stress however that during my various interviews one remark, 'You must send us your best men', occurred so frequently that I began to wonder if those I interviewed had had some unfortunate experiences with some of our graduates. I do not think this is the case, but the reason is that competition for these posts is so keen that only the best men can be placed. There is no place even for mediocrity. This is something for which the Council cannot be responsible, but I think something might be done to draw the attention of the universities to the possibility of instituting some machinery whereby they could be responsible to the Colleges in Britain, to the London Post-Graduate Federation and other similar bodies for sponsoring the graduates who wish to apply for the limited number of vacant posts. Some liaison of this nature would certainly be very helpful.

This brings me to another suggestion which I would like to bring forward—a scheme which I broached when I was in Britain in 1946 before I was a member of the Medical and Dental Council and which I again discussed with various individuals while in Britain this year—the question of establishing an interchange of registrars (or others holding similar types of posts) between Britain and South Africa and possibly between the various members of the Commonwealth.

It seems to me that some arrangement of this nature might solve a great many difficulties. No time would be wasted by graduates endeavouring to find suitable posts in Great Britain. These posts would be fixed for them before they left this country and similarly graduates from Britain would have their posts fixed for them here. These periods of training would of course be counted as part of the training required in each country and some machinery would need to be set up to make it a working proposition. It would require discussion on a high level, say with the respective Ministers of Health, the British Post-Graduate Medical Federation and, as there is no such similar Federation in the Union, with representatives of the universities here.

It appears to me that there would be great advantages from the medical point of view to all those who were accepted to take part in this scheme, for our medical problems differ in many ways; the diffusion of knowledge to the different universities and hospitals by this interchange would also be of great advantage. I feel convinced that such interchange would also be of great value from a general educational point of view to both parties.

In 1946 I felt that the practical difficulties which would require to be overcome seemed insurmountable and therefore I let the suggestion drop. But after mentioning the possibility of such a scheme to a few people during my recent visit and receiving some encouragement, I take the liberty of bringing it forward for your consideration. There will be difficulties without a doubt, e.g. difficulties of registration, adjustment of salaries, taxes, etc., but as one Doctor pointed out, the idea seems excellent and if the principle is sound, then the difficulties should not be allowed to stand in the way of working out an acceptable scheme. I feel that it may be easier to do this now, seeing that the British Ministry of Health now controls all the hospitals and that the highest authorities have expressed a desire to do everything possible to improve post-graduate education and to assist in providing such education for Dominion graduates.

## ASSOCIATION NEWS : VERENIGINGSNUUS

## NORTHERN AREAS DIVISION OF CAPE WESTERN BRANCH

## ANNUAL DINNER

The Annual Dinner of the Division was held on 4 June 1953 at the Cambridge Hotel, Milnerton.

Dr. J. R. E. Lee, Chairman of the Division, presided, and there were present Dr. F. D. du T. van Zyl, guest of honour, Dr. A. W. S. Sichel, chairman of Federal Council, Mr. R. Lane Forsyth and Dr. J. G. Louw, president and honorary secretary of Cape Western Branch, Dr. A. H. Tonkin, medical secretary, Dr. T. Shadick Higgins, editor, Dr. J. O. E. Aphor, Dr. P. Leftwich and Mr. W. L. Phillips, guests Dr. C. G. G. du Plessis, Dr. T. H. L. Jones, Mr. T. B. McMurray, Dr. H. W. Needham, Dr. M. Reznik, Dr. M. Hoffman, honorary secretary of the Division, and many others.

After a cordial foregathering and dinner the chairman

introduced Dr. Van Zyl, who spoke about the projected Northern Suburbs hospital at Bellville and the new medical faculty of the University of Stellenbosch. He mentioned that it would be the aim of the faculty to turn out competent general practitioners, and that he hoped that general practitioners would take part in the work of the hospital and the teaching of the students.

Mr. P. J. M. Retief proposed the health of the guests and Dr. Aphor replied. Mr. Murray proposed the toast of the Cape Western Branch and the Association, and Mr. Lane Forsyth replied. Dr. Hoffman also spoke. The toasts were received with enthusiasm and the function was greatly enjoyed by all present.

## OFFICIAL ANNOUNCEMENT : AMPTELIKE AANKONDIGING

## MEDICAL AID SOCIETIES

A list has been prepared containing the names of all Societies approved since January 1952, when the latest Tariff of Fees booklet was issued. Members may obtain their copies from the Honorary Secretaries of their Branches, who have been requested to assist in distributing these by enclosing them with Branch circulars or notices of meetings.

Medical House,  
35 Wale Street,  
Cape Town,  
24 June 1953.

L. M. Marchand,  
*Assistant Secretary.*

## MEDIËSE HULPVERENIGINGS

'n Naamlys is opgestel van al die verenigings wat sedert Januarie 1952 goedgekeur is, toe die jongste Tarieweboek uitgegee was. Eksemplare is deur lede verkrybaar van die Ere-Sekretaris van hul takke, wat versoek is om te help met die verspreiding daarvan deur dit in te stuit by tak-kennisgewings of omsendbriewe.

L. M. Marchand,  
*Assistant Sekretaris.*

Mediese Huis,  
Waalstraat 35,  
Kaapstad.  
24 Junie 1953.

## PASSING EVENTS

UNION OF SOUTH AFRICA  
DEPARTMENT OF HEALTHBULLETIN NO. 26 OF 1953, FOR THE 7 DAYS ENDED  
THURSDAY, 25 JUNE 1953

## PLAQUE

Nil

## SMALLPOX

Nil

## TYPHUS FEVER

*Cape Province.* Two (2) Native cases at Redoubt in the Bizana district. Diagnosis confirmed by laboratory tests.

*Transvaal.* One (1) Native case in the Wakkerstroom district. Diagnosis confirmed by laboratory tests.

## EPIDEMIC DISEASES IN OTHER COUNTRIES

At date of latest available information there existed:

*Plague.* Nil.

*Cholera* in Calcutta (India); Chalna, Dacca (Pakistan).

*Smallpox* in Bombay, Calcutta, Delhi, Kanpur, Madras, Masulipatnam, Nagapatnam (India); Lahore (Pakistan); Hanoi (Vietnam); Phnom-Penh (Cambodia); Pusan (Korea).

*Typhus Fever* in Hanoi (Vietnam).

## UNIVERSITY OF THE WITWATERSRAND

## WINTER EXAMINATIONS 1953

The University of the Witwatersrand announces that the following candidates have completed all the requirements of the Sixth Professional (Final) Examination for the degree of M.B., B.Ch.:

Beck, M.	Mphahlele, M.
Bolitho, D. P.	Penn, A. L.
Borowitz, A. H.	Rosenzweig, O. M.
Cooper, B.	Ross, B. L.
Du Toit, L. J.	Siegenberg, J.
Dyke, H. A. M.	Smith, J. C. K.
Levin, L. R.	Smith, R. le G.
Matsie, W. M.	Tobias, G. W.
Mirwisi, J.	Traub, N. E.

## ADDED ANTIBIOTICS IN FOOD

The United States Food and Drug Administration has prohibited food processors from adding antibiotics to their products. Manufacturers asked the Administration to allow them to add antibiotics but it was decided that this might make consumers insensitive to the drugs when prescribed for illnesses and lead to the evolution of strains of disease germs resistant to the antibiotics.

\* \* \*

Dr. H. Krafchik, Dermatologist, of 708 Dumbarton House, Church Street, Cape Town, who has been ill recently, has resumed practice at this address.

Mr. Jack Penn, F.R.C.S., will be away from Johannesburg for 4 months, from August to the end of November. Mr. Penn intends travelling to Scandinavia, Britain and the United States of America. In Britain he has been invited to act as guest

lecturer in Plastic Surgery at the University of Oxford, and he will attend the council meeting of the British Association of Plastic Surgeons. He has also been invited to address the American Association of Plastic and Reconstructive Surgeons at San Diego, California.

\* \* \* \*

Dr. L. H. Horwitz, M.R.C.P. (Lond.), who was attached to the Department of Medicine at the University of the Witwatersrand and the Baragwanath Hospital, is now practising as a

specialist physician at 805 Medical Centre, Jeppe Street, Johannesburg.

Telephones: Rooms: 22-9046; Residence: 44-2950.

#### ACKNOWLEDGEMENT

The Registrar of the South African Medical and Dental Council wishes to acknowledge an amount of £3 sent to him anonymously from Zomba, Nyasaland.

#### IN MEMORIAM

##### DR. C. H. KRUGER

*Dr. A. W. S. Sichel (Cape Town) writes:* By the passing of Dr. C. H. Kruger, after a lingering illness, another link with the older generation of medical practitioners in the Cape Peninsula has been broken. After graduating at Edinburgh University in 1896 and obtaining the M.D. degree of that University and the F.R.C.S. (Edin.), Dr. Kruger commenced practice in 1900 at Wynberg, Cape. On retiring from practice some 8 years ago he resided at Kenilworth for a while and then at Newlands, where he died on 11 June 1953.

He was a member of the honorary staff of the Victoria Hospital for many years and took a very active part in every phase of the work carried out in that institution. He was a foundation member and a former President of the now defunct Southern Peninsula Medical Society and a staunch member of the Cape Western Branch of the Medical Association of South Africa, becoming its President in 1925. He acted as Railway Medical Officer for the Wynberg area for many years, gaining the respect and confidence of a large circle of patients, in addition to maintaining a large private practice. At one time he served a term as a member of the old Colonial Medical Council and for 15 years was a member of the Cape Prisons Board, the duties attaching to the latter post taking him periodically as far afield as East London.

Dr. Kruger was an enthusiastic sportsman and took a keen interest in all outdoor games, an interest which never waned. He was a golfer of ability and in 1915 won the championship of the Royal Cape Golf Club, of which he was an active member for very many years. In order that his patients might not feel that he neglected their interests for golf he adopted the sobriquet of Dr. Kidney in competitions and inter-club matches. Even his medical colleagues were on occasion deceived by this ruse. When advancing years com-

peled him to give up golf he looked forward with the utmost pleasure to watching weekly cricket or football matches at Newlands. In his day Kruger was a rugby player of note. He obtained his blue at Edinburgh University and on returning to the Cape played for the Gardens Club when it was in its heyday.

He loved to hark back to the old days when he enjoyed his weekly bridge evening at one or other of his colleagues' houses and the mid-weekly four-ball at golf made up by himself and the late Drs. Steyn, Rowan and C. M. Murray, the entire four, alas, now passed on.

Kruger was one of the old type of practitioners whose personality played no small part in the conduct of a successful general practice. His surgical qualifications and experience were valuable adjuncts in his hospital work, which went back to pre-specialist days. He had a lively sense of humour and loved a good story, though when he told the story himself he often missed the point—and his hearers had to laugh from a sense of politeness.

Kruger was a lovable character who lived his life with vigour and with enthusiasm for all that he undertook, were it work or play. Like the majority of his contemporaries, he stood for a high standard of ethics, but he could be a hard task-master when it suited him. He will be remembered by his closer friends for several little idiosyncrasies, particularly his use of the Afrikaans double negative during conversation in English.

Dr. Kruger was pre-deceased by his wife and his eldest daughter, whose deaths were great shocks to him, already failing gravely in health. The family circle was a happy and devoted one in the Kruger home, and great sympathy will go out to his surviving daughters and their families.

##### DR. LOUIS SIMON VIVIAN ZINOBER

*Mr. E. Colley, F.R.C.S. (Port Elizabeth) writes:* In the passing of Dr. Louis Zinober, Port Elizabeth has suffered the loss of one of its senior medical practitioners. Dr. Zinober was educated at the Grey College, Rhodes, and the University of Cape Town, where he obtained his B.A. degree. He qualified in Medicine at the London Hospital in 1923, and later did post-graduate work in London and Vienna.

In the course of time Dr. Zinober worked up one of the biggest practices in Port Elizabeth, and became its senior partner. About 2 years ago he had a serious illness and had not been fit since. In spite of ill-health he was as fond as ever of his game of golf and it was, in fact, while on a golfing holiday that he suffered his fatal attack.

With the passing of Louis Zinober another medical personality in Port Elizabeth has disappeared. He was one of the most popular men in town. We shall always remember his cheerful disposition and the ever-ready welcome to his open house. He will be missed by his numerous patients and his colleagues alike.

He is survived by a widow and two children. Of his two brothers, Dr. M. Zinober is Radiologist to the Johannesburg General Hospital and Dr. C. Zinober was his partner in practice.

To his widow and family we extend our deepest sympathy.

#### CORRESPONDENCE

##### CORTISONE THERAPY

*To the Editor:* Of the many practitioners who will have been attracted by the importance of the subject to read Dr. M. M. Suzman's recent paper on the 'Clinical Application of Corticotropin and Cortisone Therapy' (S. Afr. Med. J., 7 March 1953, p. 195) few can have failed to glean valuable information from the impressive array of clinical experiences recorded.

Dr. Suzman's description of the successful use of cortisone to combat persistent fever in two patients with subacute bacterial endocarditis on antibiotic therapy calls to mind the frequent coexistence of subacute bacterial endocarditis and acute rheumatic lesions, which may explain the efficacy of steroid therapy in such cases. The results obtained in the treatment of rheumatoid arthritis were particularly encouraging at a time when recent reports (summarized by Thorn *et al.*,<sup>1</sup> 1953), emphasize the high incidence of side-effects

when cortisone is used in doses large enough completely to suppress the inflammatory process. The rapid improvement induced by cortisone in patients with systemic lupus erythematosus and periarthritis nodosa has been well documented, but Dr. Suzman's reference to the limitations imposed by progressive renal failure is of equal importance. It is disappointing to witness the apparent inability of the hormone to alter the inexorable progression of the renal lesions in these patients. There is little doubt that, in some patients with advanced renal insufficiency, the administration of large doses of cortisone or hydrocortisone has hastened the accumulation of oedema, precipitated convulsions and accelerated the patients' demise. In the treatment of Addisonian crisis, now that solutions of cortisone and hydrocortisone can be prepared and administered intravenously with rapid and potent metabolic activity (Thorn *et al.*<sup>2</sup> 1952), it will probably be possible to avoid some of the occasional deaths such as in the patient described, who failed to recover on large intramuscular doses of cortisone, no doubt due to inadequate absorption in the presence of poor peripheral circulation.

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2. Thorn, G. W., Jenkins, D., McCracken, B. H., Garcia-Reyes, J. A. and Reddy, W. J. (1952): Trans. Assoc. Amer. Phys., **65**, 281.

D. H. P. Streeten, M.B., M.R.C.P., D.Phil.  
*Assistant in Medicine*

Peter Bent Brigham Hospital,  
721 Huntington Avenue,  
Boston 15, Mass., U.S.A.  
8 June 1953.

#### OBESITY WITH SEX DISTURBANCE

*To the Editor:* Dr. Zwarenstein (of the Physiology Department) and I are interested in the investigation and treatment of (a) obese boys who are underdeveloped sexually; and (b) obese women who fail to conceive but who (i.e. both categories) are otherwise not abnormal.

Cases can be referred to me at the Groote Schuur hospital.

F. Forman.

Department of Clinical Medicine,  
Werner and Beit Medical Laboratories,  
University of Cape Town,  
Mowbray, C.P.  
20 June 1953.

#### NON-PAYING PATIENTS

*To the Editor:* Please allow me a little space for a complaint *pro domo suo* or rather *pro domo nostro*.

We live by our fees, the fruits of hard work, which entails much responsibility and no small risks; yet 10-20% or more of these fees never reach us. There are types of patients who just do not like paying doctors' fees. They are mostly Europeans; the non-whites either pay cash according to their means, or are referred to hospitals or else are treated *pro Deo*. Such Europeans manage to be treated from the very first 'on tick'. 'Put it down to my account,' or 'I'll pay on Friday,' or 'I'll fix you up at the end of the month.' Their account is a soap-bubble, and that Friday or that end of the month never comes. These people go around in town from one doctor to another and exploit them all in succession, month after month, year after year.

These parasites are not necessarily in financial straits. Their poverty is rather psychical, moral, lack of consideration, selfishness, a conscience devoid of scruples, or sheer moral degeneracy. Far from shy, they claim and get the best for themselves. The doctor, however, who spent hours at their bedside by day and by night, who restored their health or saved their children's life—the doctor need not be paid, need not live, as far as they are concerned.

I send out 150-200 monthly accounts. Of these 30-40 are gradually paid every month. With newly accumulated ones I have 100-150 accounts standing permanently, many of them lagging behind and dragging on for 6, 12, 24 months, not a few probably to A.D. 2000. 'The doctor must wait' is

the slogan of these good people, more especially of those who think nothing of getting one out of one's bed at 2 a.m. for a backache of 14 days' standing or for a cough 30 years old.

Credit is given too lightly nowadays. Business men probably must give it to increase their turnover—and many regret it later. We professional people, although we cannot live on air, have also another, higher reason for giving credit indiscriminately. It is the principle of not refusing aid to any sufferer, whether he pays or not. Our good faith, however, often meets with a bad reward. Unknown people are examined, treated, often given costly injections, etc. or referred further to specialists. At the end of the procedures we get an address and a promise, which, not seldom, are the last we hear of these people.

Now one starts sending the accounts and, failing any response, writing letters, nice polite letters at first, then fair reminding letters, finally more serious demanding ones. All in vain. This class of people have no use for your logic or your suggestions of decency and fair play. If one in ten replies it is another vague promise or more often an insulting letter. At last one sends the collector to them; he does succeed in some cases, but takes such a fair share of the fees that the game is hardly worth the candle.

Larger accounts one usually hands over to an attorney. The latter writes, traces the debtor, warns him, summonses him and even gets judgment; all this, make no mistake, goes to the account of the doctor, not of the patient. In about half the cases law and justice triumph and the fees are recovered. It is a Pyrrhic victory, the victor loses more than the vanquished. . . . A patient owed me £4 10s. for over a year, and tired of reasoning with him I asked a legal man to help me. He did so, and after a few months I got a cheque for 17s. 8d. as my fees. A colleague comforted me with the valuable information that for a 'handed-over' debt of £8 he received a cheque for 14s. 2d.

Similar cases happen by the dozen to many of our colleagues year in, year out. Nor is the social status of these patients a bar against their despicable devices. Middle-class and professional (non-medical) people are among those who rob doctors of their lawful earnings. The more a medico is patient, kind and moderate, the more he pays for it, the greater the exploitation.

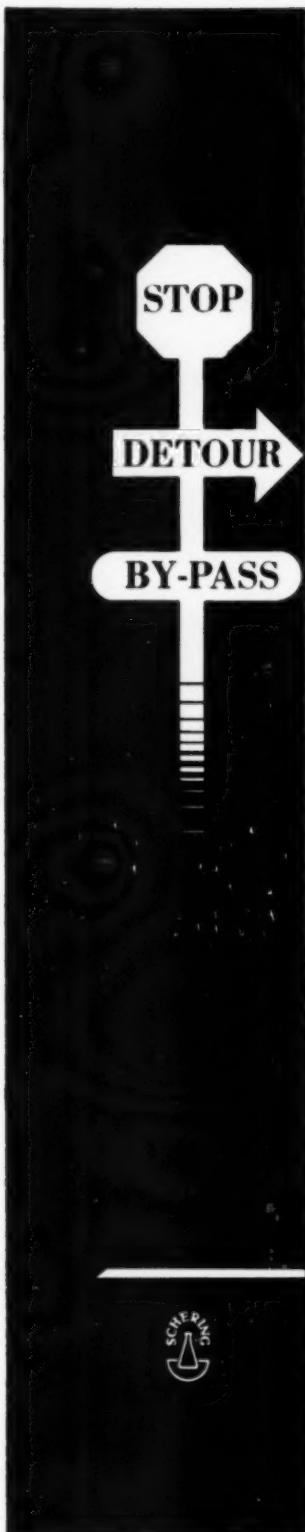
The bad defaulters simply deny their debt, or disappear without a trace. The better ones continue to make promises *ad infinitum* until one gets tired of the whole thing and writes off the account. The best ones sweetly agree that they must pay but shed such bitter tears before the attorney, pleading misfortune, widowhood, divorce and what not, that your legal adviser's heart softens (whose would not?) and he generously absolves them from paying—and you must do the same. This done, many a one returns to his motor car, his brandy, his heavy smoking and his gambling, but changes his doctor.

Our hands are tied by ethical inhibitions and, loth to publish or circulate black lists, we cannot warn one another against such rogues. I remember—a few of my colleagues probably do so too—a shrewd individual, well dressed, well spoken and always drunk, who a few years ago kept me busy for hours day and night with a variety of complaints due to drugs and alcohol. When the account passed a certain high mark I refused to see him further, only to learn that five colleagues in the same suburb had been duped by him before me. True, he landed in prison (thanks to his firm, not to any of us) but this helped us little.

Must this racket of deceiving the doctors and defrauding the chemists be allowed to go indefinitely? Many colleagues are good losers; they smile or shrug their shoulders saying, 'It's just too bad', and leave it at that. I think this is unjust to ourselves. Quite apart from frustration and waste of time, the G.P. cannot afford to lose £100-£200 (specialists much more) every year to these human pests. The Medical Association could help us through its Parliamentary Committee or a special committee including medical members of Parliament. The Minister of Justice should be asked for revision of certain laws concerning the payment of debts, or a new law for the protection of doctors against *mala fide* defaulters.

A medico's life is rendered strenuous enough by his incessant dealing with his patients' physical ills and mental aberrations; so why allow the moral nakedness and the immoral attitude of many of them to cause him additional havoc?

M. J.



## *at the very first sign of a cold*

### *its development—*

antihistaminic therapy has been reported to abort the development of the common cold in 90% of the patients commencing therapy within the first hour of the appearance of symptoms.<sup>1</sup>

### *distressing symptoms—*

antihistaminic therapy shortens the duration and decreases the severity of an established cold.<sup>1-3</sup>

### *spread of infection to others—*

the elimination of sneezing, lacrimation, rhinorrhoea and coughing reduces cross-infection.<sup>1</sup>

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combines the classical "A.P.C. formula" (Acetylsalicylic acid 3·5 gr., Acetophenetidin 2·5 gr. and Caffeine 0·5 gr.) with Chlor-Trimeton<sup>\*</sup> the antihistaminic with minimal side-effects and greater effectiveness in doses as low as 2·4 mg.<sup>2</sup>

**The Allergic Concept of the Common Cold:** The symptoms of upper respiratory infections closely resemble those found in vasomotor rhinitis and hay fever. More histamine-like substances were found in the nasal secretions of persons suffering from colds than in allergic rhinitis.

**Dosage and Timing:** Two CORICIDIN Tablets at the very first indication of a cold, then one tablet every three or four hours for three or four days. In established colds, one tablet every three or four hours for palliative effect.

**Packing:** CORICIDIN Tablets, tubes of 12, bottles of 25 and 100.

**Bibliography:** 1. Brewster, J. M.: Indust. Med. 18:217, 1949. 2. Murray, H. C.: Indust. Med. 18:215, 1949. 3. Tislow, R. and others: Federation Proc. Part I, 8:338, 1949. 4. Troescher-Elam, E.; Ancona, G.R., and Kerr, W. J.: Am. J. Physiol. 145:711, 1945. \*T. M. Schering Corporation.

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18 July 1953

## THE POST-INFLUENZAL TONIC



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*In 8 oz. and 80 oz. bottles.*

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#### Vitamin B<sub>1</sub> and glycerophosphates.

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Information: Hungunion (Pty) Limited, P.O. Box 549, Pretoria

Telegrams: ELEKTRO BUDAPEST

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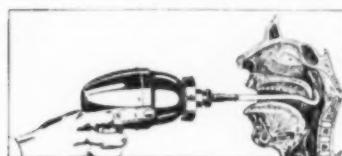
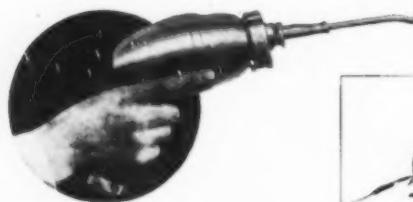
- **PROPHYLAXIS:** When disregard of warning signals such as fatigue, loss of appetite and general debility, invites respiratory infections, then Waterbury's Compound will indeed prove timely.
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JOHANNESBURG

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Illustrations show 'Kromayer' burner with post-nasal applicator, also in use, and the self-contained 'KROMAYER LAMP', Model 10.



## *Good news for DIABETICS*

Medical men with diabetic patients will be interested to know of the introduction of Rose's *Diabetic Lime Juice*. This delicious pure-fruit cordial is specially prepared without added sugar and can provide an enjoyable addition to the patient's diet. Rose's *Diabetic Lime Juice* is obtainable from Chemists and Stores everywhere.

**ROSE'S DIABETIC LIME JUICE**

# A combination of qualities

The claims of 'Dettol' do not rest on any single quality desirable in an antiseptic, but rather upon the combination of several essential properties. It can be used at fully effective strengths with safety; that is, without risk of poisoning, discomfort or damage to tissue. It retains a high bactericidal potency in the presence of blood, it is stable, and agreeable in use.

## DETTO<sup>L</sup>

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RECKITT & COLMAN (AFRICA) LTD., P.O. BOX 1097, CAPE TOWN

35

1805-IE



Made in England

South African Trade Representatives: Gurr Surgical Instruments Pty. Ltd., Harley Chambers, Kruis Street, Johannesburg

**This Diagnostic Set** for the examination of Ear, Eye, Nose and Throat, incorporates all possible improvements which have come to light during the past 20 years.

All the bright parts are finished in untarnishable chromium plate of super-excellent quality. Non-ferrous and entirely rustless alloys are used throughout, and the heavier parts, such as the Battery Handle, are made of light alloy. Housed in a handsome hard-wearing box, fitted with a newly designed catch, the instruments will always be ready for instant use and prove to have a remarkably long and trouble-free life.

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- Improved May Ophthalmoscope
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electric diagnostic instruments

## The Medical Association of South Africa : Die Mediese Vereniging van Suid-Afrika

### AGENCY DEPARTMENT : AGENTS KAP-AFDELING

#### DURBAN

112 Medical Centre, Field Street. Telephone 2-4049

#### PRACTICES FOR SALE : PRAKTYKE TE KOOP

(PD13) Natal Lower South Coast practice, near Pondoland border, suitable for retired doctor. Area developing and large Police holiday camp in vicinity. Excellent climate and very good fishing. Premium required £400, includes good stock of drugs and dressings, instruments and dispensary furniture. House for sale £1,800, including stand of one-third morgen. Bond available. For immediate sale. Owner having taken a full-time appointment.

(PD15) General practice established 1941 at pleasant residential and seaside resort about 10 miles south of Durban. Annual income approximately £1,000. No major surgery, minimum of minor surgery and only emergency midwifery being done at present. Brick house with consulting room attached, for sale at £5,250. Owing to ill health owner wishes to retire from practice as soon as possible. Premium £1,000 including drugs, surgery and dispensary furniture.

(PD20) Natal South Coast. General mixed prescribing practice with 2 surgeries 11 miles apart. Premium £1,000 plus £200 for full equipment of 2 surgeries. Large proportion of the patients are European visitors, and Indians. A lucrative Native practice could be built up if dispensing was carried out. Immediate introduction.

(PD21) East Griqualand. General mixed practice with net profit of £3,000 annually. Excellent prospects. Premium £2,150.

(PD22) Natal. Prescribing and dispensing country practice. Total gross receipts for 1951, £3,344 15s. 9d.; 1952, £2,817 10s. 6d.; 1953 (3 months), £846 6s. 10d. Premium £1,500. House for sale £6,500.

(PD23) Natal. Prescribing practice particularly suitable for a woman doctor interested in obstetrics and gynaecology. Total gross receipts for 1950, £1,570; 1951, £1,595; 1952, (6 months), £1,340; 1953 (3 months), £382. Premium £1,250, includes furniture, fittings, instruments, drugs and existing book debts.

#### PARTNER REQUIRED

(PDX) General Practitioner in Durban offers partnership, preferably to one with surgical experience. Capital necessary.

#### ASSISTENTE/PLAASVERVANGERS VERLANG ASSISTANTS LOCUMS REQUIRED

(138) Assistant required immediately in general country practice near Pietermaritzburg. £1,000 per annum. Two appointments. Very little surgery or midwifery. Should possess own car.

(139) Locum required Natal country practice. 30 August to 30 September. Must be bilingual and possess own car. £2 12s. 6d. per day, all found.

#### KAAPSTAD : CAPE TOWN

Posbus 643, Telefoon 2-6177: P.O. Box 643, Telephone 2-6177

#### PRAKTYKE TE KOOP : PRACTICES FOR SALE

(1295) Karoo hospitaaldorp. Geleë in vooruitstrewende skaapdistr. Ontvangste vir 1952: £2,640. Premie verlang: £1,250. £500 kontant, balans oor 2½ jaar. Drie aanstellings aan die praktyk verbonde.

(1349) Eastern Province hospital town. Partnership share in large busy practice. Gross income for the last year was over £5,000. Premium required £1,250. Excellent opportunity for Afrikaans doctor interested in surgery.

(1356) Very well established CAPE TOWN SUBURBAN PRACTICE. Outright sale or alternatively partnership share available to Gentile purchaser. Excellent opportunity to acquire a good class practice. Details on application.

#### CONSULTING ROOMS AVAILABLE

(1411) Specialist offers to share his excellent consulting rooms in St. George's Street; also services of nurse/receptionist.

#### ASSISTENTE/PLAASVERVANGERS VERLANG ASSISTANTS LOCUMS REQUIRED

(1347) Cape Town suburb. Gentile assistant with view to partnership. Salary offered £80—£100 per month according to qualifications. Locum must have own car.

#### JOHANNESBURG

Medical House, 5 Esselen Street, Telephone 44-9134-5, 44-0817  
Mediese Huis, Esselenstraat 5. Telephone 44-9134-5, 44-0817

#### PRAKTYKE TE KOOP : PRACTICES FOR SALE

(Pr/S77) Transvaal. Aangename privaat praktyk. Gemiddelde jaarlike inkomste oorskrei £3,000. Elektriese krag. Gerieflike moderne woonhuis op twee erwe en moderne spreekkamers op aangrensende 2 erwe. Woonhuis teen £3,500 indien verlang en spreekkamers teen £1,500. Premie £1,750. Terme kan gereel word, asook ruime verband.

(Pr/S81) Oos-Vrystaat. Geen opposisie. D.G. aanstelling teen £425 p.j. Jaarlikse inkomste £2,500. Premie van £750 sluit praktyk-toerusting, instrumente en medisyne in. As volg betaalbaar: £300 kontant en balans op maandelikse paaiemente; die bedrag waarvan onderling gereel kan word.

(Pr/S82) Excellent non-European practice near Johannesburg. Established in 1944. Average annual *net* income £2,700 cash. Premium required is £2,000 and terms can be arranged. Premium includes contents of surgery and maternity ward.

(Pr/S83) Prescribing practice in Southern Rhodesia. Modern hospital. One transferable appointment at £300 p.a. Income 1951—£5,600; 1952—£6,200 and that of 1953 possibly in the region of £7,000 to £8,000. Excellent opportunity for man with surgical and maternity experience. House for sale or to let. Premium required £3,500 on terms or £3,000 cash.

(Pr/S84) Oud-gevestigde Vrystaatse praktyk met D.G. aanstelling. Gemiddelde jaarlike inkomste oorskrei £4,000. Premie van £2,000, sluit medisyne en apparate in. Uitstekende geleentheid vir 'n jong man.

(Pr/S84) Pleasant town in Northern Transvaal, with hospital facilities. General practice which was run by seller for 10 years besides a large non-transferable mine appointment. The Appointment did not allow time for any Native work—only for very few district calls. Net cash income over £1,200 per year though only few hours daily were spent in this practice. Premium £500 on terms. Excellent start for a young man.

(Pr/S85) Progressive Transvaal dispensing practice. Excellent surgical facilities. Average gross income £3,500 per annum. Premium required £2,500 and the following terms could be arranged: £1,250 deposit and the balance over a period of 18 months, starting 3 months after cash payment. The premium includes drugs, furniture and fittings, estimated at £800. Two transferable appointments worth £230 per annum. Scope for expansion.

(Pr/S86) Pretoria practice with two appointments. Annual income over £3,000. Long introduction will be given. Premium of £1,500 includes furniture, instruments and drugs. Terms will be accepted.

#### ASSISTENTE/PLAASVERVANGERS VERLANG ASSISTANTS LOCUMS REQUIRED

(L/V373) O.V.S. Vanaf 1 tot 24 Augustus. Salaris £2 12s. 6d. per dag, vry per tol en olie en losies en 'n kartoelae van £10 per 1,000 myl, plus bedrag gelykstaande aan 'n eersteklas reiskaartjie vanaf verbylples.

(L/V406) O.V.S. Vir 3 weke in Augustus. Salaris £2 12s. 6d. per dag, vry losies en 8d. per myl vir ritte buite 'n 3 myl area.

(L/V410) O.F.S. August. Salary £70 p.m. and all found. No car necessary. No night work and no week-end work. Very easy practice.

(L/V411) Assistantship offered. To start 1 August. A house available. Tvl. town 90 miles from Johannesburg.

(L/V412) O.F.S. Assistant required in partnership practice, as from 1 August. Must be bilingual. As there is a view to partnership only applicants who have had a reasonable G.P. experience need apply. Salary £100—£150 p.m. depending on experience.

(L/V413) Bilingual assistant required for practice 25 miles from Johannesburg. Salary and commission. Surgical facilities. View to partnership.

(L/V414) Assistantship offered by partnership practice in Johannesburg. Very large practice. If suitable, a partnership will be offered. Preferably Gentile, and an ex-service man. Must use own car. Will suit person interested in surgery. Personal interview will be arranged.

## Provincial Administration of the Cape of Good Hope

### HOSPITALS DEPARTMENT

#### CARINUS NURSING COLLEGE, CAPE TOWN: LECTURES TO STUDENT NURSES

1. Applications are invited from registered medical practitioners to lecture to student nurses at the Carinus Nursing College, Cape Town, in the following subject for period ending 1 August 1954:
  1. Gynaecology: English medium, 6 lectures per course; 3 courses per annum.
  2. Lectures to be given between the hours 8.45 a.m. to 12.45 p.m., each lecture to be of one hour's duration.
  3. Lecturer will be remunerated at the rate of £1 1s. per lecture and 1s. per examination paper corrected.
  4. Further particulars are obtainable from the Principal, Carinus Nursing College, Cape Town.
  5. Application must be made on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Branch Representative of the Hospitals Department, P.O. Box 1487, Cape Town, or from the Medical Superintendent of any Provincial Hospital or Secretary of any School Board in the Cape Province.
  6. Applications must be addressed to the Director of Hospital Services, P.O. Box 2060, Cape Town, and must reach him not later than 12 August 1953. (A562652)

### Locum Wanted

Southern Rhodesia, country district. Three guineas per diem, and all found. Car not essential. For 3 weeks—August to September 1953. Reply to P.O. Box 28, Banket, Southern Rhodesia.

*Showell's*



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Sole Distributors for the Union of South Africa

*Chas. F. Thackray*

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23 Orion House, 235 Bree St. (P.O. Box 2726) JOHANNESBURG

## Provinsiale Administrasie van die Kaap die Goeie Hoop

### HOSPITAALDEPARTEMENT

#### CARINUS-VERPLEGGINGSKOLLEGE, KAAPSTAD: LESINGS VIR LEERLINGVERPLEEGSTERS

1. Aansoek word ingewag van geregistreerde geneesherre om lesings aan leerlingverpleegsters aan die Carinus-verplegingskollege, Kaapstad, te gee in die volgende vak vir die tydperk eindigend 1 Augustus 1954:

1. Ginekologie: Engels medium, 6 lesings per kursus; 3 kursus per jaar.

2. Lesings moet gegee word tussen die ure 8.45 v.m. tot 12.45 n.m. Elke lesing moet een uur duur.

3. Lektor sal besoldig word teen £1 1s. per lesing en 1s. vir elke vraestel wat nagesien word.

4. Nadere besonderhede is verkrygbaar by die Prinsipale, Carinus-verplegingskollege, Kaapstad.

5. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrybaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Takverteerwoordiger van die Hospitaaldepartement, Posbus 1487, Kaapstad, of by die Mediese Superintendant van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaap-provincie.

6. Aansoek moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word, en moet hom nie later as 12 Augustus 1953 bereik nie. (A562652)

## Southern Rhodesia Government

### VACANCY: MEDICAL OFFICER OF HEALTH (FEMALE)

Applications are invited from European candidates for the undermentioned post in the service of the Southern Rhodesia Government.

The following allowance is at present payable in addition to salary:

Children's allowance: To officers in receipt of a salary of £2,009 per annum or less.

Successful applicants must obtain a satisfactory medical certificate issued by a Southern Rhodesia Government Medical Officer.

The cost of rail fare plus subsistence allowance from place of recruitment to place of employment will be refunded to successful applicants. Half the cost of rail fares will be refunded in respect of families.

Appointments are subject to the rules and regulations of the Southern Rhodesia Civil Service, and to the applicant obtaining a Southern Rhodesia Residence Permit.

Applications, giving full details of age, nationality, qualifications, experience, war service, marital state, together with copies of testimonials and giving dates of availability, should be made to the Head of the Department concerned, who will supply further information on request.

Canvassing will disqualify applicants.

Applicants should hold a Diploma in Public Health or a Diploma in Child Health and experience in Schools Medical work will be an advantage. Duties will also include environmental hygiene in rural areas and prevention of endemic and epidemic disease.

Commencing emoluments are £1,530 per annum, with a maximum of £1,722 per annum on the grade.

Full particulars may be obtained from the Secretary for Health, P.O. Box 93, Causeway, Salisbury, Southern Rhodesia. Closing date 31 July 1953. (7347)

### Practice for Sale

Natal: Urban general mixed practice, solus. Nett receipts £2,750 per annum. House for sale as well. Apply 'A. R. E.', P.O. Box 643, Cape Town.

## Provincial Administration of the Cape of Good Hope

### HOSPITALS DEPARTMENT

#### VACANCY: MEDICAL STAFF

Applications are invited from registered medical practitioners for appointment to the post of medical practitioner, Grade A, on the staff of the Provincial Hospital, Port Elizabeth, with salary at the rate of £500—£600—£720 per annum.

In addition to the rate of pay indicated a variable cost-of-living allowance at rates prescribed from time to time by the Administrator of the Province is payable. (Current rates: Married men, £320 per annum; others, £100 per annum.)

The privileges of free board, quarters and laundering are not attached to this post.

The conditions of service are prescribed by the Hospital Board Service Ordinance No. 19 of 1941 (Cape) and the regulations framed thereunder.

Applications must be made on the prescribed form (Staff 23), which is obtainable from the Medical Superintendent of the Provincial Hospital, Gipson Road (P.O. Box 80), Port Elizabeth, to whom applications must be addressed to reach his office not later than 14 August 1953.

J. H. McLean  
Medical Superintendent

Port Elizabeth  
2 July 1953 (10332)

#### Medical Officer Required

Applications are invited for the post of part-time Medical Officer to the United Tobacco Companies (South) Limited, 72, Church Street, Rustenburg.

Particulars of the appointment, which includes daily attendance at the Factory and pre-employment examinations, may be obtained from the Factory Manager.

(This appointment has the approval of the Medical Association of South Africa.—Assistant Secretary, M.A.S.A.)

## Provincial Administration of the Cape of Good Hope

### HOSPITALS DEPARTMENT

#### CONRADIE HOSPITAL, PINELANDS, CAPE

#### VACANCY: HONORARY MEDICAL OFFICER

Applications are invited from registered medical practitioners under the age of 60 years for appointment to the above-mentioned post.

The appointment will be made in terms of and be subject to the Hospitals Ordinance (No. 18 of 1946) Cape, as amended and to the rules and regulations of the Department, and will in the first place be for the period ending 31 December 1953, after which the honorary medical establishment may be revised.

Applications should state full particulars of age, qualifications, experience, etc., be accompanied by copies of recent testimonials, and should be forwarded to reach the Medical Superintendent, Pinelands, Cape, not later than noon on Monday, 3 August 1953. (586)

## Transvaalse Proviniale Administrasie

### VAKATURES BY PUBLIEKE HOSPITALE

Aansoeke word ingewag van kandidate met gesikte kwalifikasies vir die onderstaande poste by Publieke Hospitale in die Transvala.

Aansoeke moet gerig word aan die Geneeskundige Superintendent of Verantwoordelike Geneesheer van die betrokke Hospitaal en moet volle besonderhede bevat aangaande die ouderdom, professionele, akademiese en taalkwalifikasies, ondervinding en huwelikstaat van die applikant en moet voorts 'n aanduiding bevat van die vroegste datum waarop diens aanvaar kan word:

Lewenskostetoeleae tans betaalbaar aan voltydse werknemers:

	<i>Salaris</i>	<i>Lewenskostetoeleae</i>
Oor £350 .. .. ..	£320 p.j.	£100 p.j.

Van persone wat aangestel word, sal verwag word om bevredigende sertifikate in te dien, asook om hulle te onderwerp aan 'n geneeskundige ondersoek by die betrokke hospitaal.

Aansoeke vorms is verkrygbaar van enige Transvaalse Publieke Hospitaal of die Proviniale Sekretaris, Afdeling Hospitaal-dienste, Posbus 2060, Pretoria.

Benewens jaarlikse salaris en lewenskostetoeleae ontvang voltydse werknemers spoorwegkonseissie en word verlof toegestaan ooreenkomsdig die hospitaal verlofregulasies.

Die sluitingsdatum van aansoeke vir die poste is 27 Julie 1953.

<i>Hospitaal</i>	<i>Vakture</i>	<i>Emolumente</i>	<i>Opmerkings</i>
Edenvale	Ongevalle-beampte (1)	£620, 780 820, 860.	Geregistreerde mediese praktisyne.
PK. Raedene.	Verantwoordelike Geneesheer (1)	£1,000 X 50-1,200	Geregistreerde mediese praktisyne. Administratiewe pligte. Plus vry huis of £180 per jaar huis toeue.
Lydenburg.			
			(41599)

#### Assistant Wanted

Assistant wanted for unlimited period in hospital town in Witwatersrand area. Must supply own car, petrol, oil, etc. Approximately 400 miles a month. Remuneration, £100 a month inclusive. Apply 'A. R. G.', P.O. Box 643, Cape Town.

## Provinsiale Administrasie van die Kaap die Goeie Hoop

### HOSPITAALDEPARTEMENT

#### CONRADIE HOSPITAAL, PINELANDS, KAAP

#### VAKATURE: ERE MEDIESE BEAMPTE

Aansoeke word ingewag van geregistreerde mediese praktisyne onder die ouderdom van 60 jaar vir aanstelling in die bo-gemelde pos.

Die aanstelling geskied ingevolge en is onderhewig aan die Ordonnansie op Hospitaal, No. 18 van 1946 (Kaap) soos gewysig, en die reëls en regulasies van die Departement, en ten eerste sal dit vir die tydperk beëindig 31 Desember 1953 van krag wees, waarna die Ere Mediese diensstaat hersien mag word.

Aansoeke moet volle besonderhede meld van ouderdom, kwalifikasies, ondervinding ens., moet vergestel wees van afskrifte van onlangse getuigskefte, en moet aan die Mediese Superintendent, Conradie Hospitaal, Pinelands, gerig word om hom nie later as middag op Maandag 3 Augustus 1953, te bereik nie. (586)

## Provincial Administration of the Cape of Good Hope/University of Cape Town:

### JOINT MEDICAL STAFF FOR GROOTE SCHUUR HOSPITAL: VACANCIES

1. Applications are invited from registered medical practitioners for appointment to the following vacant posts on the Joint Medical Staff of the Groote Schuur Hospital:

1 post of Medical Practitioner, Grade C (Assistant Medical Superintendent), salary on the scale £1,000 x 50—£1,200 per annum.

1 post of Medical Practitioner, Grade D (Third Assistant), Department of Medicine, salary on the scale £1,200 x 50—£1,500 per annum.

2. Conditions of service are prescribed in terms of Hospital Board Service Ordinance No. 19 of 1941, as amended, and the regulations framed thereunder.

3. In addition to the scale of salary indicated a cost-of-living allowance at rates prescribed from time to time by the Administrator is payable to whole-time officials and employees.

4. The successful candidate for the post of Medical Practitioner, Grade C (Assistant Medical Superintendent), will be required to occupy free of charge an unfurnished house or quarters provided at the institution or, alternatively, if a house or quarters are not available to occupy a house provided by the Department in respect of which the Department will contribute an amount of not exceeding £180 per annum towards the rental.

5. Candidates for the post of Medical Practitioner, Grade D, must be registered specialists in the Department in which the vacancy exists.

6. The Joint Medical Staff is required to serve jointly the Provincial Administration of the Cape of Good Hope and the University of Cape Town.

7. The successful candidate, if not already in the Hospital Board Service, will be required to submit satisfactory birth and health certificates.

8. Application must be made on the prescribed form (Staff 23) which is obtainable from the Director of Hospital Services, P.O. Box 2060, Cape Town, or from the Branch Representative of the Hospitals Department, P.O. Box 1487, Cape Town, or from the Medical Superintendent of any Provincial Hospital or Secretary of any School Board in the Cape Province.

9. The closing date for the receipt of applications is 10 September 1953, and applications should be addressed to the Director of Hospital Services, P.O. Box 2060, Cape Town.

10. Candidates must state the earliest date on which they can assume duty. (A562653)

## City of Kimberley

### MEDICAL OFFICER

Applications are hereby invited from registered medical practitioners for the post of Clinical Officer in the service of the City Council on the grade £900 x 50—£1,150, plus temporary cost-of-living allowance.

The successful applicant will be required to undertake clinical work and such other duties as the Medical Officer of Health may determine.

Applications stating age, marital state, qualifications and experience, the earliest date duties may be assumed, and accompanied by copies of not more than three recent testimonials, must reach the undersigned not later than Thursday, 30 July 1953.

R. Hartley Marriott  
Town Clerk

Town Office  
Kimberley  
26 June 1953

(2283)



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MEDICAL HOUSE, 35 Wale Street, Cape Town. P.O. Box 643. Telephone 2-6177. Telegrams: 'Medical'

## Provinsiale Administrasie van die Kaap die Goeie Hoop/Universiteit van Kaapstad:

### GESAMENTLIKE MEDIESE PERSONEEL VIR GROOTE SCHUUR-HOSPITAAL: VAKATURES

1. Aansoeke word ingewag van geregistreerde geneesherre vir aanstelling tot die ondergemelde vakante posse op die Gesamentlike Mediese Personeel van die Groote Schuur-hospitaal:

1 pos van Geneesheer, Graad C (Assistent Mediese Superintendent), salaris volgens die skaal £1,000 x 50—£1,200 per jaar.

1 pos van Geneesheer, Graad D (Derde Assistent), Departement van Geneeskunde, salaris op die skaal £1,200 x 50—£1,500 per jaar.

2. Die diensvooraardes is voorgeskryf ingevolge die Ordonnansie op Hospitaalraadsdiens nr. 19 van 1941, soos gewysig, en die regulasies wat daarfragtens opgestel is.

3. Beweens die salarisskaal soos aangedui is 'n duurtoeslag betaalbaar aan voltydse beambtes en werknemers teen bedrae wat van tyd tot tyd deur die Administrateur vasgestel word.

4. Van die geslaagde kandidate vir die pos van Geneesheer, Graad C (Assistent Mediese Superintendent), sal dit vereis word om 'n ongemeubileerde huis of kwartiere wat by die hospitaal verskaf word gratis te bewoon, of as 'n huis of kwartiere nie beskikbaar is nie, 'n huis te bewoon wat deur die Departement goedgekeur is ten opsigte waarvan die Departement 'n bedrag van hoogstens £180 per jaar tot die huur sal bydra.

5. Kandidate vir die pos van Geneesheer, Graad D (Derde Assistent), moet geregistreerde spesialiste wees as 'n spesialis waarin die vakature bestaan.

6. Van die Gesamentlike Mediese Personeel sal vereis word om die Provinsiale Administrasie van die Kaap die Goeie Hoop en die Universiteit van Kaapstad gesamentlik te dien.

7. Die geslaagde kandidate, indien nie reeds in die Hospitaalraadsdiens nie, moet bevredigende geboorte- en gesondheidserfekte indien.

8. Aansoek moet gedoen word op die voorgeskrewe vorm (Staf 23) wat verkrybaar is by die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, of by die Takverteenwoorder van die Hospitaaldepartement, Posbus 1487, Kaapstad, of by die Mediese Superintendent van enige provinsiale hospitaal of by die Sekretaris van enige Skoolraad in die Kaapprovinse.

9. Die sluitingsdatum vir die ontvangs van aansoeke is 10 September 1953. Aansoeke moet aan die Direkteur van Hospitaaldienste, Posbus 2060, Kaapstad, gerig word.

10. Kandidate moet die vroegste datum meld waarop hulle diens kan aanvaar. (A562653)

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18 July 1953

announcing  
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nasal congestion

FENOX, an entirely new preparation of phenylephrine hydrochloride and naphazoline nitrate, marks an advance in the local treatment of catarrhal conditions of the nasal passages and accessory sinuses. The basic theoretical considerations leading to the formulation of FENOX have been more than justified; critical evaluation of the clinical efficacy of FENOX confirms its superiority as a nasal decongestant. Symptomatic treatment of nasal catarrh is directed towards clearing the nasal airway and promoting sinus drainage by reducing congestion and re-establishing the physiological defence mechanisms of the nasal cavity. Decongestion can be accomplished by vasoconstriction, but the value of most vasoconstrictors is limited by their tendency to cause secondary dilatation and systemic reactions.

The ideal nasal decongestant will be of approximately the same pH, tonicity and viscosity as normal nasal secretion and will not interfere with normal ciliary activity; in addition, it will be non-irritant, non-toxic and free from undesirable effects. FENOX most nearly meets these requirements; no other preparation exhibits all the properties and advantages of this new nasal medicament.

*The efficacy of FENOX may be considered from the following main aspects:—*

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Literature and further information on request from Medical Information Department

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